This dilemma leads to a point where the HCW is encouraged to practice beyond his knowledge and abilities. He is further encouraged by the vast variety of drugs available in the local bazaars and the accessibility of "fancy" instruments from Quetta and Peshawar.

Changes in the Local Health Care Picture

A few unexpected and spontaneous changes in the local health care picture were discovered, which fortunately, parallel changes desired by those concerned with developing an integrated health care system in Afghanistan.

HCWs in large numbers were initially trained by NGOs for the war effort. Emphasis was placed on first aid and surgical/trauma skills. The HCW generally moved from place to place as battle sites changed, and frequently, clinics had to be relocated because of attack or other security reasons.

Now, the fighting in Kandahar has diminished and is basically confined to two locations. This leaves many men in stable situations with new roles to play and different population demands to address. Men trained by different NGO programs, and men with "experience" but no formal training, are consolidating their efforts and labors by joining together to share facilities, personnel, and drug supplies. Many clinics had members from a variety of training programs and drug supply sources working together. Stable clinic teams are forming and the autonomous mobile worker is becoming an element of the past.

Refugee families have begun to trickle back and the internally displaced are moving to "safe" areas, specifically, the villages of Panjwai and Khwajamolk. These villages are <u>usually</u> well supplied with goods from Pakistan (remember the Tarnak River). Because there is food and safety, the local population is increasing. The clinics in these areas are seeing more women and children and fewer mujahideen. This shift in patient profile has forced the HCWs to address the problems of primary care, instead of trauma. The framework of primary care, public health, and prevention of illness is established. This is a new concept for rural Afghanistan, and we did find a few potential converts amongst the HCWs.

These local developments, even in their infancy, parallel continuing concerns of the World Health Organization (WHO), the Agency Coordinating Body for Afghan Relief (ACBAR), and South West Afghanistan Baluchistan Association for Coordination (SWABAC) to promote integration of medical services, to redirect training efforts toward the delivery of primary care, disease prevention, and public health, and to focus attention on womens' health care issues.

III. RETRAINING/TRAINING

The need for retraining and training has been recognized for some time, but seeing the necessity at the local level was dramatic. HCW skills have become less effective because of environmental pressures and the length of time since initial training. They are now having to respond to changes in health care focus. Assuming resettlement becomes a reality in the foreseeable future, retraining/training should have started yesterday.

A few considerations regarding the identification and selection of potential individuals become apparent. A likely candidate would ideally:

- show an interest in being retrained/trained and having supervision of his consultations and referrals.
- show an interest in further education, such as:
  - specialty areas (eg. laboratory, xray, management).
  - women's health problems and/or dais training
  - public health/prevention of illness.
- show an ability to provide a more advanced level of health care
- already be seeing a large number of patients
- have been working in an area for more than one year
- be accepted by the patient community
- have the support of the local authority figures
- be located in a suitable catchment area that fits into a broadbased plan of regional integration of health care

Location of Training Facilities

Practically, at least for the HCW, retraining/training facilities should be located inside Afghanistan. Education needs to be tailored to local problems for maximum effectiveness. Many of these men do not have the money to travel outside and support their families at the same time. The day to day hardships families encounter in the simple process of living are nearly insurmountable. The manpower of whole families is needed for the major reconstruction efforts of rebuilding homes and restoring the food supply (Afghans are already starting to repair karezes and canals without waiting for foreign assistance).

Locating Potential Candidates

Locating potential retraining/training candidates will be a problem. Monitoring missions need to establish specific criteria for identifying interested parties. All monitoring missions (not necessarily medical)--both technical and non technical, both expatriate and Afghan--should include brief specific questions in their questionnaires geared to identification of potential training candidates. The medical questionnaire used in this mission also included brief considerations of population, housing, commodities, and agriculture. Local authority figures and groups usually have good information about the quality of work being done in their areas.

Using the already established drug resupply lines, circulation of printed material could be used to notify returning HCWs of the search for interested individuals. Ideas from returning HCWs could be used to help formulate local or regional training programs. Supply lines in Peshawar and Quetta, as well as inside deliveries, are all potential vehicles for the distribution of information. Announcements asking HCWs to come forward could be sent back inside to alert others in the same position.

Resource People Needed

There is a dramatic need for resource people to begin the job of re-education. Suggestions regarding what these people should potentially be able to do include:

- Assess and upgrade diagnostic and treatment skills
- Advise about clinic management, especially skills of recordkeeping, including patient statistics and drug inventory
- Be a role model to introduce more advanced or alternative health care practices
- Work with the HCWs to tailor solutions to specific problems of his community
- Stimulate concern and create awareness of public health/preventative issues and their impact on the future
- Begin to address the overlooked areas of physical disability and mental health.

The use of Afghan physicians familiar with training/retraining programs are the ultimate ideal candidates. They are able to integrate training levels and to establish retraining focuses at the appropriate levels.

IV. SUMMARY LIST OF CMC, IAHC, AND ICRC TRAINED HCWs BY DISTRICT

1. PANJWAI

1. Ghulam Farooq s/o Juma Khan Unknown	MCI	Sale Han 24/3/89	Comm:Daoud Party:Nidjat-e-Milli
2. Abdul Qayum s/o Abdul Armon Unknown	MCI		
3. Abdullah s/o Nassrudin Unknown	MCI		
	Commander Daoud was in Piralizai Camp Baluchistan. HCWs unknown by local population.		
4. Mullah Ahmad s/o Abdul Razock Interviewed	MCI Clinic	Pashmoll 27/3/89	Amir: Sayed Akbar Agha Party: Hezb-I-Khales
5. Issamudin s/o Sadrudin Interviewed			
6. Mohamad Shariff s/o Ghulam Mahmad Not seen	MCI SCA Clinic	Pashmoll 27/3/89	
7. Mirajuddin s/o Najmuddin (also working in Panjwai bazaar) Not seen	MCI		
8. Faez Mahmad s/o Sher Mahmad (also working in Mianjoy, Arghandab) Not seen	MCI		
9. Gul Agha s/o Mahmad Abdul Satar Agha Interviewed	MCI		

10.	Sayed Jamaludin s/o Serajudin Not seen	MCI MSH Clinic	Tulukan 22/4/89	Amir:Said Zia Uldin Comm:Nazer Mamad Party:Mahaz-e-Milli
11.	Abdul Quader s/o Haji Noor Ali Not seen	MCI MSH		
12.	Juma Gul s/o Sharafudin Fired by MCI in January 1989 Brief interview	MCI SCA Clinic	Tululkan 22/4/89	Amir:Haji Nadir Comm:Ghulam Azrat Party:Hezb-I- Hekmatyar
13.	Mahmad Nader Agha Not seen	MSH	Punjwai Bazaar 23/3/89	
14.	Noor Ahmad Interviewed	IAHC Clinic	Punjwai Bazaar 20/3/89-23/3/89	Amir:Sayed Akbar Agha
15.	Mirajudin s/o Najhudin Interviewed	IAHC		
16.	Obaidullah s/o Abdul Haq Interviewed	IAHC		
17.	Sahib Shah aka Shah Mahmad s/o Noor Mohd Jan Agha Not seen	MSH	Tululkan 22/4/89	Amir:Artar Mahmad Comm:Nazar Mahmad Party:Mahaz e Milli (with Jamiat before)
18.	Haji Abdul Hakim Interviewed	MSH MCI Clinic	Zalakhan 13/3/89	Comm:Fazludin Agha Party:Mahaz e Milli
19.	Dr.Jabar Interviewed	MCI Clinic	Nakhuni 14/3/89	Comm:Mullah Mallang Party:Hezb-i-Khales
20.	Mir Ahmad Interviewed	MCI		
21.	Abdullah Interviewed	MCI		
22.	Ali Mahmad Interviewed	MCI		
23.	Noor Mahmad Interviewed	MCI		

24.	Gullam Yaya Not seen	MCI		
25.	Mirajan Not seen	MCI		
26.	Abdul Manon Not seen	MCI		
27.	Essa Mohamad Unknown	SCA	Nakhuni	Amir:Mullah Shazada Comm:Haji Doctor Party:Ittehad e Islami
28.	Mahmad Zaher s/o Mahmad Qasim Interviewed	MCI Clinic	Zalakhan	Comm:Maolklawi Abdul Rahim Party:Hezb-I-Khales
29.	Gulam Mahmad Not seen	MCI		
30.	Mahmad Nahim Not seen	MCI		

2. DAND/DAMAN

31.	Bismullah	MCI Clinic	Nave Kallacha 24/4/89	Amir:Haji Latiff Comm:Abdullah Jan
32.	Nessar Ahmad s/o Haji Faez Mahmad	MCI		
33.	Abdul Armon s/o Abdul Rahim Interviewed	MCI Clinic	Shir-e-Surkh 24/4/89	Amir:Abdul Riaz Comm:Haji Sher Party: Jamiat e Islami
34.	Rahullah s/o Mira Jan Not seen	MCI		
35.	Abdul Latiff s/o Abdull Khaleq Not seen	MCI		
36.	Ahmadullah Not seen	MCI		

37. Haji Razock Unknown	MSH	With Mujahideen 24/4/89	Comm:Haji Razeck Party: Hezb-I Hekmatyar
38. Mahmad Ismael s/o Shazada Not seen	MSH	Rawanay 24/4/89	Comm:Esmat Party:ANLF
39. Ahmaddin s/o Sherafudin Not seen	MSH	Khossro 23/4/89	Comm:Haji Commandant
40. Ayatullah s/o Mussa Jan Not seen	MSH Clinic	Chaplanay 14/3/89	Amir:Mohamad Sedeq (Interviewed) Comm:Sher Ali Party:Mahaz e Milli
41. Fazel Rahin Agha s/o Shazada Agha Not seen	MCI Clinic	Yakh Karrez 23/4/89	Amir: Mullah Shazada Comm:Haji Doctor Party:Ittehad e Islami
42. Khaleq Dad Not seen	MCI		
43. Wahid Sedek aka Mahmad Sedek s/o Lal Momamad Brief interview	MSH/MCI Clinic		Amir:Mullah Shazada Comm:Haji Doctor Party:Ittehad e Islami
44. Ali Mahmad Not seen	MSH Clinic	Yakh Karrez 23/4/89	Comm:Sarranwall (Interviewed) Party: Mahaz-e-Milli
45. Abdul Armon Not seen	MCI		
46. Khallil Not seen	MCI		
47. Ghulam Mohanadin s/o Essamudin Not seen		Yakh Karrez	Comm:M. Nadim Party:ANLF
48. Abdul Hadey s/o Haji Yakh Mohamad Interviewed	ICRC Clinic	Gurgan 15/3/89	Comm:Mahmad Sedek Khan Party Mahaz e Milli

3. ARGHANDAB

49. Mahmad Zafran s/o Abdulah Interviewed	MSH Clinic	Char Gul Bagh 18/4/89	Amir:Mullah Naqibullah Akhunzada Comm:Khan Mahmad Party:Jamiat e Islami
50. Fate Mahmad s/o Mussa Jan Interviewed	SCA		
51. Mullah Mahazullah s/o Muschkia Allan Not seen	MSH		
52. Nehamatullah Not seen	MSH		
53. Mohamad Khallos s/o Abdul Barki Not seen	MSH		
54. Abdul Qayum Not seen	MSH		
55. Khalillulah s/o Haji Habibullah Not seen	SCA		
56. Esbollah s/o Habi Yakh Mahmad Not seen	SCA		
57. Abdul Hadey s/o Haji Abdullah Jan Not seen	SCA		
58. Karimullah s/o Abdul Rhzock Not seen	SCA		
59. Abdul Wahad s/o Abdul Razock Interviewed	SCA	Mian Shuhin 16/4/89	

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Kandahar Province

60.	Sayed Abdul Bahaludin Agha s/o Qbaidullah Ahga Not Seen	MCI Clinic	Mian Shuhin 16/4/89	Amir:Fanidullah Akhunzada Comm:Mullah Assadullah Akhun Assist:Mullah Tur Akhun Party:Harakat Enquelab
61.	Assadullah s/o Mahmad Azom Interviewed	SCA Clinic	Mian Shuhin 17/4/89	Amir:Mullah Abdul Malek Akhun Comm:Sultan Mahmad Party:Harakat Enquelab
62.	Shah Massud Not seen	SCA	Mian Shuhin	Comm:Fazel Mahmad Party:ANLF
63.	Fazel Armon s/o Mohamad Anif Seen - brief interview	SCA Clinic		
64.	Abdul Haye s/o Abdul Hakim Seen - brief interview	SCA		
65.	Serrahtullah s/o Mir Kalla Seen - brief interview	SCA		
66.	Abdul Razock Seen	SCA Clinic	Surkh Challa 18/4/89	Amir:Mullah Nakibullah Akhunzada Party:Jamiat e Islami
67.	Rahmatullah Not seen	SCA	Khessro	Comm:Akani Party:Hezb-I-Hekmatyar (was Sayaaf 3 mths ago)
68.	Mahmad Daoud Not seen	SCA		Comm: Akani Party:Hezb-I Hekmatyar
69.	Abdul Walli s/o Khudai Rahim Not seen	MCI MSH Clinic	Shuhin Babor 19/4/89	Comm:Obaidullah (Interviewd) Party:Hezb-I-Hekmatyar
70.	Abdullah Not seen	MCI		

71. Attiqullah s/o Abdul Ghani Interviewed	MCI Clinic	Mianjoy Char Bagh 28/3/89	Amir:Sayed Akbar Agha Comm:Mullah Abdul Haq Agha Party:Hezb-I-Khales
72. Faez Mohamad s/o Sher Mahmad (Also worked in Pashmoll/Punjwai) Not seen	MCI	Mianjoy Char Bagh	
73. Abdul Rahim s/o Habibullah Not seen	MCI		
74. Mullah Mumim Not seen	MCI		
75. Sadrudin Not seen	MCI		
76. Din Mahmad Not seen	MCI Clinic	Trained Taabin Sufla 20/4/89	Amir:Haji Assadullah Party: Hezb-I-Hekmatyar
77. Mahmad Armon Seen	MCI	Trained	
78. Rahmatullah Not seen	MCI	Trained	
79. Abdullah Not seen	MCI	Trained	Amir:Odji Assadullah Party:Hezb-I-Hekmatyar
80. Bobey Not seen	MCI	Trained	
81. Sayed Rassull s/o Sultan Mahmad Interviewed	MCI Clinic	Khwajamolk 10/4/89	Amir:Mullah Nakibullah Akhunzada Party: Jamiat Islami
82. Khalilullah s/o Hadji Habibullah Interviewed	MCI		
83. Sali Mohamad s/o Haji Yakh Mahmad Interviewed	MCI		

84. Baber Gul s/o Abdullah Karim Seen - brief interview	MSH	Khwajamolk 12/4/89	
85. Abdul Jalil Not seen	MSH Clinic	Khwajamolk	
86. Gul Mahmad s/o Fhez Mahmad Interviewed	MSH Clinic	Khwajamolk	
87. Mohamad Zaman s/o Haji Azizullah Interviewed	IMC Clinic	Khwajamolk 11/4/89	

4. MAIWAND

88. Abdul Haye s/o Rostam Seen	MSH MCI Clinic	Sangi Sarr 5/4/89	Amir:Mullah Faezullah Akhunzada Comm:Mullah Abdul Hakim Party:Harakat Enquelab
89. Hyder Shah s/o Kallah Shah Seen-brief interview (was SCA until February '89) (accepted MCI in May '89)	SCA MCI		
90. Akbar Shah s/o Kallah Shah Interviewed	MCI		
91. Nakibullah s/o Faezullah Akhunzada Seen	MCI		
92. Nehamatullah s/o Abdull Armon Not seen	MSH Clinic	Nadai 4/4/89	Comm:Mohamad Hussein Agha (interviewed) Party:Mahaz e Milli
93. Mohamad Sedek s/o Haji Obaidullah Not seen	MSH	Nahre Karrez 4/4/89	Comm:Rahmatullah (Interviewed) Party:ANLF
94. Karimullah s/o Haji Obaidullah Not seen	MSH		Comm:Gul Agha Party:ANLF

95. Agha E Gul s/o Ghulam Mayeddin Interviewed	MCI Clinic	Mira Khokh Kalla 6/4/89	Amir:Mullah Faezullah Akhun Comm:Mullah Issam Jan Party: Harakat Enquelab
96. Mahmad Sedek s/o Aka Gul Seen	MCI		
97. Sediqullah Sedek s/o Hamidullah Interviewd	MTA Clinic	Sangi Sarr Barakzai Kalla 3/4/89	Amir:Sayed Amed Agha Comm:Sardar Mamad Party:Mahaz e Milli

5. SPIN BOLDACK

98. Khan Mohamad s/o Gul Mohd Unknown	MSH	Kadanai	Amir:Satar Khan Comm:Abdul Razaq Party:ANLF

V. SUMMARY OF INFORMATION

Practitioner Interview - Summary of Responses

Major causes of death in the region in order of reported incidence:

War related injuries	Measles
Cholera	Pneumonia - children
T.B.	Female birth complications
Malaria	Diarrhea
Typhoid	Constipation

In the Detailed Report we frequently mention the individual's description of typhoid and cholera. The differences in symptoms seen was inconsistent, so no clear picture was derived. Diarrhea was a constant theme, with ocassional mention of "rice water" stools. Many HCWs mentioned cholera as the second cause of death, the first being war related injuries.

The symptom 'diarrhea' was mentioned but the cause was not known. Death from constipation was attributed to a diet consisting of mostly potatoes and bread.

- Major risks problems in the region:

  - unsafe water - polluted by human use or poisons
  - insects which transmit diseases (mosquitoes, flies, and fleas)
  - lack of good quality food, or sufficient food at times
  - milk infected with TB
  - malnutrition (mentioned as a separate item not necessarily related to food - see malnutrition section)

- Future professional plans:

  Most all HCWs responded that they wanted to continue working in the health care field and upgrade their skills to the nurse or doctor level.
  Those owning land locally desired to remain in the rural areas. Those with no land or families nearby wished to practice in a large city. Generally, the better educated HCWs preferred to be employed in more urban areas because they assume there will eventually be higher level care facilities.

- Future desires for Afghan health care and educational opportunities:

  - a full service provincial hospital in Kandahar City
  - a clinic in every woleswali
  - schools for physician and nurse training (7)
  - women's medical university
  - sanitation program run by the government
  - malaria program run by the government
  - vaccination program run by the government
  - help for the physically disabled including schools and training

- What was and what was not generally useful in training programs:

useful	not useful
first aid	mathematics
surgery and anatomy	information concerning:
airway management	women
controlling hemorrhage	cancer
management of emergencies	goiters
	vaccines

Clinic Services

As a general pattern, clinics are open from 8am - 12 noon and 2pm - 4pm (7-10pm Ramazan). Most HCWs live at the facilities and can provide 24 hour emergency care.

The larger clinics generally have the following services: (see Detailed Report for individual descriptions of larger vs. smaller clinics)

consultation (OPD) and prescription
minor surgical procedures
dental
laboratory
pharmacy
hospitalization
X-ray (1 in Nakhunay being repaired)
transportation (for HCW and patient transportation)

The services of the smaller clinics are mostly confined to:

consultation and prescription
first aid
wound care

Generally any HCW is at liberty to provide those services he feels his patients need or want, that he believes he can manage, and for which he has equipment. This freedom can allow the HCW to venture into areas far beyond his level of education. Many examples of the problem are noted in the Detailed Report. (see Interview With Dr. Balouch - Detailed Report appendix).

We found no expatriate staff in Kandahar except a Syrian M.D. working in an Arab clinic in Arghandab.

General Condition of Clinics

The clinics were constructed with mud brick, had straw and mud woven ceilings, wooden windows and doors, and dirt floors. Most sites visited were single room structures.

The degree of cleanliness and order was more related to personal interest and efforts, rather than to level of education or resources. The range was from the dismal to well above expected standards. Many inventive and ingenious methods were found to compensate for lack of equipment and adequate space. We saw a camera tripod used as an IV pole and a treatment room set up in a camping tent.

Training program instructors would be well advised to consider more closely the field conditions in which the HCW is actually practicing. We are training under relatively ideal circumstances (eg. supplies, equipment, facilities) and returning people to situations that are dramatically different.

Clinic Location and Access

Most of the clinics were located in mujahideen markazs (military camps) which, by social definition, prohibit access to women of child bearing age and many children. These markazs were not generally located in populated areas, and since the war efforts have decreased, the HCWs are seeing few male war wounded.

The three facilities with the best staffing, most supplies and relatively well educated HCWs were: (see Detailed Report for elaboration of problems)

- Mercy Corps International (MCI) Nakhunay clinic with a graduated M.D. It was poorly located and was, therefore, seeing few patients numbers (15-20/day).

- Islamic Aid Health Center (IAHC) Panjwai bazaar clinic was well located and seeing 75-100 patients/day, but had rules limiting the access of women.

- MCI Khwajamolk bazaar clinic was well located, served the entire population, and was serving patient numbers of 30-50/day.

The obvious suggestion here is to move the markaz clinics to areas which will serve wider community needs and better utilize the existing staff. As the refugees return new areas will be identified. There are already ample facilities in the two largest villages of Panjwai and Khwajamolk.

Road access to these markaz points is at times barely possible in good weather, and is impossible during the rainy season. The state of disrepair is mostly a result of war destruction. The roads were also not originally constructed with clinic transportation in mind.

Equipment

Detailed lists of equipment contained in each clinic appear in the Detailed Report. Some general comments are mentioned here.

Basically, any equipment considered as "fancy" or complex is not well utilized. In relatively long established clinics, shiny microscopes and sterilizing equipment were seen in original packaging tucked in corners and rather dusty. (see Sterilization for possible reasons for under utilization)

Many laboratories generally appeared not to be operating up to potential and were mostly under utilized. Frequently, there was a lack of reagents and specialized equipment necessary for performing studies. The reason for this was unclear and possibly has to do with problems in supply source.

One X-ray machine was in the Kandahar area we visited, but was non-functional. Plans have been made for repair.

Dental equipment is incomplete because of improper supply, loss, and theft. A set of pliers was the frequent alternative, including one hand made set that would have better served the camel population.

There is no equipment for malnutrition and growth monitoring except an ocassional adult scale. We saw no arm circumference tapes or monitoring records.

Reference and Health Education Material

There was a dramatic lack of reference materials. The most commonly encountered sources were:

German Afghanistan Committee Standard Drug Formulary
Where There Is No Doctor
Quick Index of Medical Pharmacuticals (QIMP)
Class notes from training programs

One ORS teaching poster was seen; other than this, no other educational materials were found.

HCWs frequently expressed their need and desire for more educational materials to review and upgrade their skills. They did not ask for health education materials to teach others.

Sterilization

During the entire trip not one sterile instrument was found.

One MCI clinic had Formol prepared sterile dressings but, except for prepackaged individually wrapped gauze pads, no other sterile dressing material was available.

HCWs can verbalize techniques of sterilization, but are not doing it. The reason for this situation is not clear. Possibly:

- they do not understand the basic concept
- they feel they can control problems of sepsis with antibiotics alone
- wood for fuel is scarce and is reserved for cooking (deforestation is a dramatic problem)
- kerosene is expensive and usually used to run a generator or other light source as a priority
- using an autoclave or pressure cooker is perceived as an involved process, and possibly not really worth the effort in the first place

Formol tablets seem to be a good standard supply alternative, except for the expense. They are:

- transportable through drug resupply lines
- the concept and use is easy to understand
- no fuel is necessary
- less equipment is needed
- However, unless the HCW believes in the necessity, is trained appropriately, and is willing to expend the effort this method will also fail.

One wonders how much "sterility" generally needs to be maintained considering the field conditions. It does not seem that HCWs have received realistic training concerning sterilization. If not given realistic goals for sterility, particularly when the results are not immediately obvious, poor compliance can be expected. One point of emphasis: sterile needles for injections should be a priority over instruments and dressings, if one is forced to choose.

Sanitation

Latrines

Two latrines were found during the mission. In reconstruction, rebuilding latrines is seemingly not considered a priority at this time.

Water

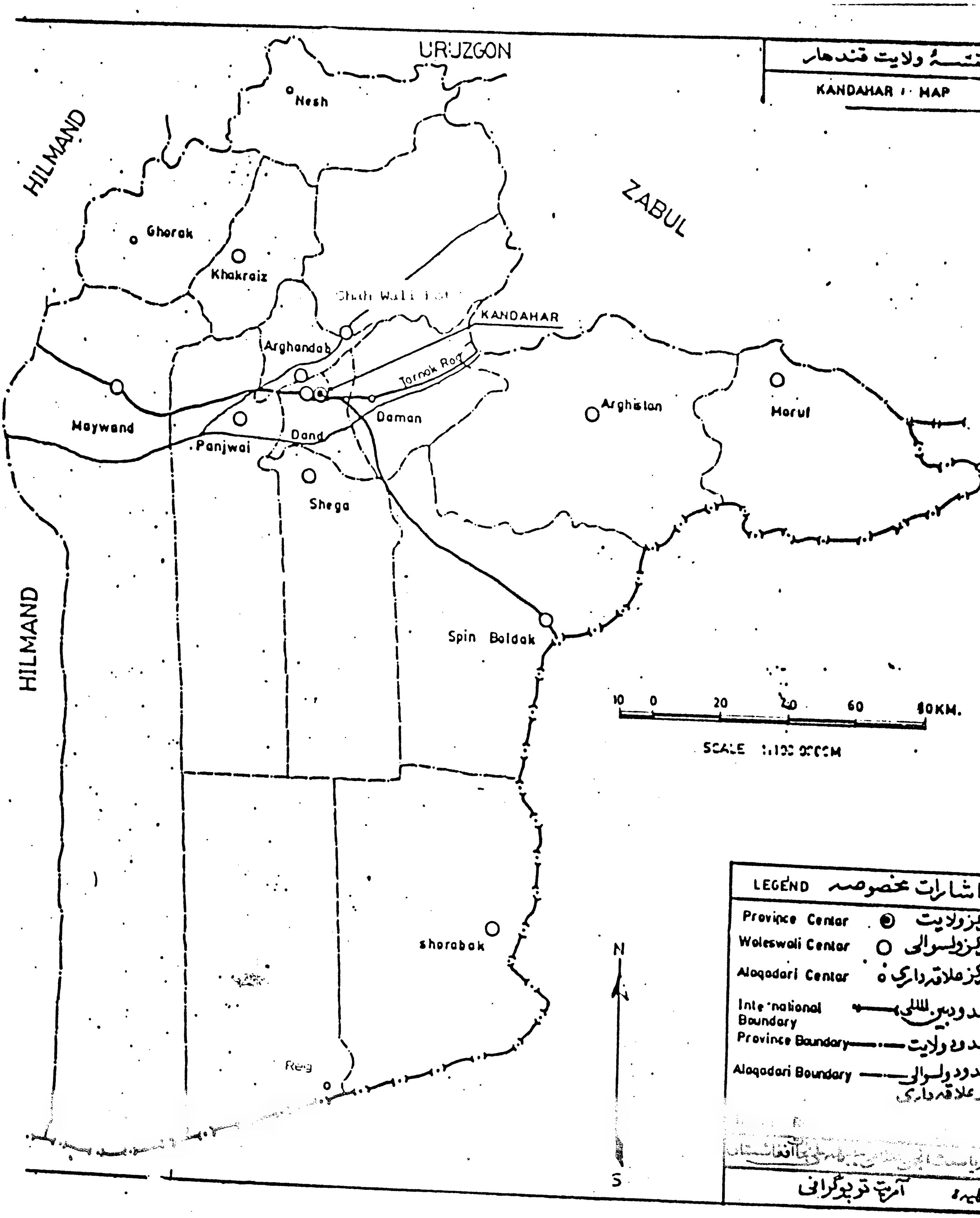
Water comes from four sources: wells, karezes (underground water system), canals, and jois (ditch).

Wells are usually 6-8 meters deep, uncovered, and unprotected. Many are believed to be contaminated by dead animals or poison, and have not been cleaned during the war. Therefore, many of them are not used. Wells at ablution sites are considered safe.

Karezes and canals are nearly all destroyed. The water carried by those in good repair is brown and muddy. It is used for ablution, drinking, cooking, washing of clothes and bodies, and drinking water for animals.
No water is boiled before drinking and only two HCWs boiled water for clinic use (wound care).

Only two metal containers for handwashing were found on the mission. One was located in the kitchen of an MCI clinic. The other was located, more appropriately in an MCI clinic court yard accessible to all, and had soap provided.

Mostly, if water was present at the clinics, it was carried from the source and placed in 1 liter green plastic jugs. The majority of hand washing observed was done with alcohol or Savlon, not water.



ولایت قندهار
KANDAHAR MAP
URUZGON
HILMAND
ZABUL
Nesh
Ghorak
Khakraiz
Arghandab
KANDAHAR
Tarnak Rod
Maywand
Panjwai
Dand
Daman
Arghistan
Maruf
Shega
Spin Boldak
Shorabak
Reg
HILMAND
10 0 20 40 60 80KM.
SCALE
LEGEND
اشارات مخصوصه
Province Center
Woleswali Center
Aloqadari Center
International Boundary
Province Boundary
Aloqadari Boundary
N
S

Medical Waste

Medical waste is thrown into the vineyards, over the compound walls, in canals, bomb craters, fox holes, or abandoned rooms. Ocassionally some trash was burned but rarely buried. The refuse collections contained packaging material, empty vials, and dressings, but no syringes. Disposable syringes are saved and reused by the clinic workers or picked up by the locals for home use. No attempt was made to sterilize needles. Training program curriculum should be "hammering this point home" as a basic necessity.

Hospitalization

Few in-house hospitalization facilities or supplies were available. Patients are mostly kept in general sleeping quarters and can not be provided with sheets, towels, gowns, or soap.

The one exception to the norm was an MCI clinic, which had sheets (but no "laundry service"), and waste baskets, water pitchers, and IV poles for each hospitalized patient.

Critically ill patients are generally sent to Pakistan via the Khwajamolk transport system or by private car (see - Referral to Other Health Care Options for details). The average length of hospitalization in Afghanistan is one night.

One Medical Training for Afghans (MTA) trained HCW mentioned that he hospitalized a patient for isolation (the only mention of isolation on the trip). Most are kept for wound care, fractures or because they have nowhere else to go.

Medication: Supply Line, Administration, Inventory and Storage

Generally, the HCW returns to Pakistan at 3-6 month intervals for resupply, or he obtains drugs locally. Please refer to the Detailed Report for specific individual problems (eg. Haji Abdul Hakim, MSH, Zalakhan, Panjwai), and descriptions of different processes and steps involved.

Supply Sources: Summary of Responses

- Main suppliers of medications - cost paid by:

Pakistan	Afghanistan
SCA	Commander/Party
MSH	Arab organizations
IAHC	Local traditional authority figures:
MCI	Qaazi (judge)
	Khan
	Rish safed (elder)

SCA - Swedish Committee for Afghanistan
MSH - Management Services for Health

- Duration of time spent obtaining resupply:

  Quetta: 14-25 days depending on road conditions
  Peshawar: 30-45 days depending on road conditions, problems at resupply distribution site, and encounters with police.

The resupply time can vary greatly depending upon other factors, such as debriefing interviews, retraining, or social visits.

- Cost - Example of one health care worker's expenditures travelling by public or rented vehicle (see - Detailed Report for individual clinic figures):

Mian Shohin - Quetta	400-500 Rs.
Quetta - Peshawar	260 Rs.
Peshawar - Quetta (131kg x 2.5 Rs.)	327 Rs.
Quetta - Chaman	800 Rs.
bribe at border check point	300 Rs.
Chaman - Mian Shohin	650 Rs.

- Method of transportation:
  Rented vehicle and ocassionally, commander/Party vehicle.

- Packaging: considered adequate by both HCWs and monitors.
  - mostly burlap, wood, and plastic are used.

- Complaints voiced regarding resupply:

  - Too much time wasted in obtaining medication resupply - would like a depot inside Afghanistan or in Chaman.

- Many extra expenses incurred in journey which HCWs do not have funds to pay. As examples: hotel and food bills due to delays, and police bribes.

- Bribes to Pakistani police at the Chaman/Afghanistan border and elsewhere. Police attitude - "you sell the drugs anyway, so give us money".

- Want tea boxes (wood) and not cardboard boxes.

- Syrups break and leak on tablets. No other complaints (eg. crushed tablets, broken glass) were generally mentioned.

- Difficult crossing the Tarnak and Arghandab Rivers at certain times during the year.

Administration of Medication

- Most of the drugs administered by the HCWs are basically benign and given primarily for sound medical and oftentimes social reasons (according to the HCWs level of knowledge).

- There was a strong tendency to venture into areas of treatment and prescription that would be better handled by other treatment methods. Example: HCWs should refer for T.B., and treatment of Leishmaniasis. This problem relates to the need to begin appropriate programs for treatment.

- Since there is a vast array of drugs from all over the world in the bazaars, the HCW can prescribe any drug he can name (see Inventory of Panjwai Bazaar Pharmacy - Detailed Report appendix). Generally, the larger clinics wrote bazaar prescriptions for 25% of their patients, the smaller clinics 50-75%. The feeling expressed was that, if the HCW did not buy or prescribe from bazaar, the patients would not come to him.

- Considering a mostly illiterate population, almost no written instructions are included when dispensing medications, and multiple drugs are placed in one packet. Often these mixtures are carried home to women by the boys with the responsibility to remember type, frequency, and dosage of the medications. In a few cases packaging as suggested in Where There Is No Doctor was at hand, but not filled in. This problem could use more training program emphasis.

- A distressing misuse of antibiotics was encountered. There was total lack of understanding regarding the long range effects of over or under prescribing. Over prescribing increases resistance and program costs, and decreases implementation of public health measures. Inadequate dose or regimen results in ineffective treatment with chronic or prolonged disease resulting.

  Problems:

  - use of antibiotics for conditions that do not require them

  - multiple antibiotic given at the same time ("shot gun" method)

  - inaccurate mg/kg/day - most often expressed excuse - "not enough supply" - "no scale"

- Frequent mixing of multiple drugs in IV solutions (compatibility) and administration of drugs by direct IV push (undiluted). These methods are inconsistent with training program protocols, but somehow the lessons have been missed. Greater attention needs to be focused on these two wide spread problems.

Inventory

- One clinic (MCI) kept a drug inventory.
- No Green Book drug inventory record was seen.
- Summary of responses

under supply	over supply
All injectibles especially antibiotics and pain medications	Multivitamins
Serums	Ferrous Sulfate
	Trisil
	Xylocaine
	Benzyl Benzoate
	ORS
	Tetracycline eye ointment
	Lugol solution

Storage

- Amounts ranging from a very large collection stock piled by one commander, to clinics with barely anything except aspirin and multivitamins.

- The water table is high in Kandahar, so there are problems with moisture and humidity. This is especially apparent near the Arghandab River which periodically floods. Thus, cardboard boxes are a problem here.
- Other storage problems include rats eating serums and drugs, and contending with the ever present dust and sand.

Referrals To Other Health Care Options

Summary of reported cases referred to Pakistan:

war trauma
    head, chest and abdominal injuries
T.B.
peritonitis
appendicitis
cancer
diabetes
heart problems
infertility problems

Many lower level health care workers are treating T.B. by prescribing drugs from the bazaar. The Detailed Report includes many examples of treatment, none of them adequate. The better educated HCWs refer patients to Pakistan, but do not use referral notes or suggest treatment facilities.

Referral to Pakistan:

Transportation to Pakistan is found in Khwajamolk bazaar, Arghandab. It is the main transport site for commodities and people going to and from the Kandahar area and Quetta.

The options are:

- rental of private car
    - Khwajamolk to Chaman 800 Rs.
- public transportation
    - Khwajamolk to Chaman 300-400 Rs.
- Arab ambulances (2) in Khwajamolk
- Commander/Party vehicle for mujahideen and selected others.

Mention was made that sometimes people in the transport business have to be forced to carry the wounded. The injured or ill get to Khwajamolk from the surrounding areas by car, truck, motorcycle, lorry, tractor, camel, donkey, horse, foot, or charpoy (bed - requires six people to carry).

Local Referral Options:

- There are government hospitals in Kandahar City and Maiwand City, but most people are afraid to visit because of risk of capture or death. These areas are government controlled

- Mir Weiss Hospital, Kandahar City, was a public hospital and is now mostly non-functional due to bombardment and lack of staff (see Report on Kandahar City Hospitals and M.D.'s Detailed Report appendix)

- Dr. Jabar, a graduate doctor receives some referrals in the MCI Mullah Malang, Nakhunay, Panjwai clinic. He has been working here for approximately three months

- A Syrian M.D. working at an Arab clinic in Khwajamolk receives some referrals, although some HCWs express reservations about dealing with the Arabs, and thus hesitate to refer

- HCWs may refer to clinics that have specialized facilities (laboratory) or services (circumcision). (see - Detailed Report for further details)

- Dr. Balouch in Panjwai is the local well respected 'surgeon' doing most of the amputations in the area. He is self taught and began his career as a sweeper in a doctor's office. (see Dr. Balouch Interview - Detailed Report appendix).

Patient Registers ("Green Books")

Green Books are not generally in use. Many excuses were offered as to why:

- lost, damaged, or "kept at home"
- sent to Pakistan (many HCWs had gone for resupply)
- with the commander who is making statistics
- with another HCW at a different site

Approximately four HCWs were observed using Green Books when seeing patients. Of these one was not including dates and the others were forgetting to enter some of the patients seen. In no case were the drug inventory or disease by sex and age categories filled out.

It appears as if the HCWs understand the Green Book as simply a tool for resupply. Mostly, they put it in order before making the trip to Pakistan. We saw many "doctored" books with these examples:

- diagnoses taken from text books and treatment taken from pharmacology books (perhaps useful for review of diagnosis and prescriptions)

- pages filled in ahead or entries lacking for days or weeks

- sex changed from male to female to reflect that more women are seen

- ages changed from older to younger to reflect that more children are seen

Perhaps the changing of ages and sexes results from the HCWs perception that training programs or suppliers want these "messages".

The larger facilities kept separate registers for treatments and dressings, laboratory, dental and surgery. These entries by-passed the Green Book usually used in the OPD consulting area.

One would consider these books as generally unreliable for generating statistics regarding disease patterns and people affected inside Afghanistan. If the HCW was able to realize the importance of collecting this information to permit the formulation of future planning, possibly one could expect better cooperation. This lack of understanding leads to the need to reteach/teach management skills.

Also, training programs need to decide what their record keeping system priorities are. For example:

- follow up clinic use
- statistical or epidemiological survey
- retraining/training information gathered by HCWs writing questions regarding particular cases not understood
- symptom oriented vs. diagnostic entries to help identify disease patterns missed by misdiagnosis (eg. what is cholera? - see multiple descriptions of it in Detailed Report)
- assisting the HCW in seeing a utility in record keeping that meets his needs

<u>Women</u> - Kandahar a Pushtoon Tribal area

- There is no need to elaborate upon the inacessibility of Afghan women to health care. This is a dramatic concern recognized by many. (8)

- Women receive health care by describing their symptoms to a male member of the family, often a young boy, who visits the clinic and lists the symptoms to a male HCW. Many times the actual problems are not stated due to modesty. The male then carries a bag of drugs with verbal instructions back home. Usually multiple drugs are prescribed further complicating the issue of trying to remember type, frequency, and duration of administration.

- Most clinics are located in markazs. One clinic prohibits visits by women. One HCW was told by his instructors in Peshawar that it was not his business to treat women and that he should refer them to Pakistan.

- Examinations permissible vs. not permissible:
  - BP over the clothing - BP under clothing of older women
  - Oral temperature permitted by all
  - Auscultation over clothing or under clothing with the help of the patient or husband
  - Abdominal palpation over the clothing, except for older women or trauma victims. One HCW stated that 10% of the men allowed inspection of the abdomen if there was "a lot of blood"
  - One HCW catheterized a woman who was anuric for two days

- Dr. Jabar, a graduate physician working at the MCI Mullah Malang clinic in Nakhonay, Panjwai, states that the most frequent female problems he sees are:

  infertility
  dysmenorrhea
  vaginal discharge
  infection after delivery
  bleeding after delivery

  A mid level HCW working at the same clinic states that he mostly sees women for problems of:

  T.B.
  fever
  diarrhea
  skin diseases
  hypertension (older women)

- No HCWs admitted having contact with local dais. Two individuals identified in the Detailed Report had outstanding rapport with their women patients, and could be encouraged to do dai training.

- No use was made of the women's waiting areas, which seem like good places to start patient education. A captive audience is present, would seem to enjoy the diversion, and might even carry the messages home.

Vaccination

Two AVICEN vaccinators have been working in Sukh Challa, 7 km from Khwajamolk bazaar. They have been vaccinating since 8/3/89. (see - AVICEN Detailed Report - appendix)

Measles - DPTP - BCG	ages 0-5	male and female
Tetanus		ages 6-14 females

IAHC Lala Malang clinic in Panjwai bazaar, and Dr. Haqani, Quetta have been trying to establish a vaccination program in conjunction with UNICEF. The program is still in the logistical planning stage.

Dr. Jabar at the MCI Mullah Malang clinic in Nakhunay would like to vaccinate children ages 0-18 for T.B., pertussis, and measles. They sent one HCW to AVICEN for training, but he was unable to complete the course.

Some attempts at vaccinating are being made by HCWs trained in camps in Pakistan. They feel they understand the process and are proceeding on their own.

Malnutrition

There seems to be great confusion as to what malnutrition means to the HCWs. Some say they see a great deal, and some say they see none. Adequate food is available for the number of people in the area, although it lacks great variety and is sometimes costly when the rivers make passage to Pakistan impossible.

The cases of malnutrition seen by the monitors were a result of improper feeding due to poor education. This was especially evident in children of weaning age and in children whose mothers lacked adequate milk. One woman with this problem had been feeding her child a mixture of grass seeds and tea.

The diagnosis of malnutrition is rarely entered in the Green Books as such. Entries are made of symptoms such as weakness, diarrhea, or vomiting. Of course, diagnosis is difficult lacking the necessary equipment.

Equipment if provided, would probably not be used due to the general lack of HCW understanding of identifying and treating the problem.

I. INTRODUCTION

MONITORING MISSION DETAILS

The goal of the Coordination of Medical Committees' (CMC) 3rd monitoring mission was to locate health care workers (HCWs) and facilities in order to provide feedback to CMC members by:

1. Verifying the presence of HCW and clinics.

2. Evaluating the quality of health care services provided by observation of patient contact, patient registers ("Green Books"), management and organization of facilities, medical supply and physical clinic structure.

3. Identifying HCWs with potential and interest in retraining/expanded training.

4. Examining the local health care picture "in situ".

5. Identifying health care facilities with potential for enhancement and/or upgrading with the idea of incorporating them into a regional health planning scheme.

6. Gathering a general picture of resettlement issues affecting health care.

Personnel

The mission began on March 3, 1989 and left from Chaman, Pakistan. There were four principal members of the party with occasional additions of a driver, driver's assistant and mujahid guard.

1. Francis Galichet, nurse, 6 years experience working in Afghanistan with Medecins Sans Frontieres.
   Languages French, English, and Farsi.

2. Mary E. Dean, Registered nurse, 7 months experience training Afghan paramedics in the northern area of Northwest Frontier Province, Pakistan.
   Languages English and Farsi.

3. Said Pacha, translator from Kabul and Kunar province.
   Languages Farsi, Urdu, French, and Pushtu.

VI. RECOMMENDATIONS AND CONCLUSION

1. ROADS - A basic necessity in any infrastructure, they must be repaired before successful relief efforts and permanent installations can be considered.

2. Karez and canal repair to provide water for agriculture (food).

3. Mine clearance to save the Kuchi nomads from having to complete the task by themselves. (9)

4. Afghan women health care workers need to be identified to train other Afghan women. This is the only realistic means of assuring accessibility of women to health care at this time. (10)

5. Expatriate women health care workers - A massive international campaign to find women to help, in short term, train female Afghan health care workers. Suggestion: advertise in professional journals, travel and outdoor magazines.

6. Health care workers retraining/training - Support and encourage using a standardized core curriculum as recommended by WHO/ACBAR/SWABAC. (11)

7. Reference material appropriate to the level of health care worker education. (12) Suggestions: CMC: A Practical Guide to Common Illnesses in Afghanistan, (13) and Where There Is No Doctor, (14) and Where There Is No Dentist. (15) Materials such as these, and others, would have great impact relative to the expenditure and could be distributed through drug resupply lines already in existence.

8. Health education materials and posters oriented toward specific ethnic groups, suitably constructed of materials which will withstand the abuses of handling and travels. (16) (17)

9. Standardization of health care practices through:
   - standardized skills check list for each health care worker level, from which is developed:
     - standardized medical supply
     - job descriptions, chains of authority and supervision
     - standardized salaries

   These concepts have already been created by community consensus and adopted by WHO. (18) (19) (20)

10. Competency based evaluation examinations, and subsequent certification, to enable the health care worker to be successfully integrated in to the future health care system, when it evolves. (20)

11. Information management. Collection of available data for evaluation and planning as currently being implemented and expanded by WHO. (20)

12. Identification of suitable sites for upgrading and establishing regional health care facilities - located through monitoring missions and review of pre-war information. (21)

13. Coordinated immunization, tuberculosis, malaria and communicable disease campaigns to provide a "basic level of wellness" until an integrated health care system is realized. These projects are already in planning through WHO/UNICEF/AVICEN and other NGO efforts. (22) (23 (24)

14. Clean water and sanitation are not priority issues at the moment, but need to be addressed anticipating the return of large numbers of refugees, especially to the urban areas. (25)

15. Physically disabled - Considering the numbers affected the needs are dramatic - prosthesis, physiotherapy, rehabilitation, and psychological reintegration. Training plans are being implemented to teach Afghan health care workers to work with the disabled within their own social system. (26) (27) (28) (29) (30)

16. Mental health - An often overlooked area considering the devastating effects of the disintegration of personal lives and war abuses. (31) (32) (33) (34)

CONCLUSION

There is presently no strong Central Government in rural Afghanistan. The NGOs and other agencies are doing what is usually the function of the Central Government; policy planning, evaluation, training, medication and equipment supply, and economic assistance for salaries and maintenance expenses. Until a broad-based Central Government is in place, this situation is expected to continue as long as assistance from foreign organizations is needed, or until it is deemed unnecessary or destructive to the values of the emerging government.

The obvious need is for a coordinated planning model resulting in standard implementation strategies. Certain types of autonomy by individual projects may be destructive to Afghanistan (eg. inconsistent HCW training, uncoordinated immunization and TB programs, competition over specific geographical areas, use of inappropriate authority models for implementation).

The role of coordination must come from the humanitarian aid agencies and enforced by donor sources. Programs must be accountable to the future needs and economic capacity of Afghanistan. Other types of creative and locally adapted programs with good results should be encouraged and evaluated. Both planning and evaluation phases are in process. Lessons of history should not be ignored nor flexibility suppressed.

We must never forget that we are guests of the Afghans, permitted to share in helping them solve their own problems. We are guests in their country. As such, we are compelled to include our hosts at evey level of planning, but more importantly our advice should be offered bearing in mind that the Afghans, through history, have always been the prime determinants of their own destiny.

Acknowledgement

With deep appreciation, I (Mary Dean) thank Dr. Sharon McDonnell for her valuable suggestions and Diane Pratt for her typing efforts well above and beyond the call of duty.

NOTE: The contents of the report of CMC Monitoring Mission #3 to Kandahar province include thoughts and opinions of a CMC contracted medical monitor(s) which may or may not reflect official CMC policy.

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VIII. APPENDICES

Appendix 1.

RESETTLEMENT

Introduction: Resettlement Questionnaire

The CMC questionnaire prepared for the 3rd mission included general resettlement questions to give an idea of the local shelter, population, education, food and agriculture issues affecting the returning refugees. Prices of local commodities are also included.

Since mostly HCWs were interviewed, the answers reflect their knowledge of the above considerations, which was sometimes incomplete. Some were not from the interview area, some may have been too young to remember prewar statistics, and some may not have been involved in agriculture before the war.

In spite of the limitations of the survey, the information was useful and interesting. It also provides another view of the frame work in which the health care worker functions.

PANJWAI DISTRICT

People Interviewed:
- Abdul Saman - Mujahadeen from Pashmoll
- Besmullah Jan - Cook from Panjwai bazaar
- Mullah Ahmad - HCW living in Panjwai

Pashmoll - Village

Population before war	10,000 families
Villages surrounding	40
Families left since war	100%
Families returned	0
Housing destroyed	100%
Rebuilt	20%

Panjwai Bazaar - Village

Population before war	5,000 families
Population now	7,000

Internally displaced families have migrated here and are living with ultiple families in remaining intact structures.
Area is well protected by and in control of mujahideen, and perceived as safe by migrants.

Original families returned	0
Housing destroyed	70%
Rebuilt	30%

SHELTER

Materials needed for rebuilding not available locally.
Wood, stone, steel for beams and roofing, and cement (straw and ceiling cane - now not enough being grown)

Cost - 1 family house
5 Lak - mud brick
12 Lak - kiln brick

POPULATION

Emigrated to:

Kabul:	0	Pakistan:	95% Quetta
Iran:	0	Afghanistan:	3-5% Herat

Population left: 9 years ago

Refugees returning: 0

Comments about repatriation:
"Refugees will not return until government troops leave".

POLITICAL DIFFERENCES

Preventing repatriation denied.

EDUCATION

Pashmoll - No schools

Panjwai Bazaar - 2 madrasa schools to 5th class
boys and girls attend.
monetary support from IAHC - (Dr. Haqani/Quetta)
provides salaries, supplies, and books from Arabs.
No "public schools".

FOOD AND AGRICULTURE

Pashmoll

Aabi land cultivated before war	600 jeribs
Lalmi land cultivated	Unknown
Aabi land	50% unproductive now

Comments:
"The people have left, irrigation is destroyed, land was burnt, and people are afraid of mines".

Panjwai Bazaar

Aabi and Lalmi land cultivated	Unknown by persons interviewed.

#1 "I'm not from this area"
#2 "I was too young, I can't remember"

Seed

Seed available in bazaar -
Comes from Pakistan and Jalalabad
Some was "brought by foreigners"
Does not know about the quality - heard it was not as good as what was available before the war.
Enough seed available - no one to plant it, no water.

Fertilizer

Seen in bazaar - believes it comes from Pakistan.

Major locally grown agriculture products

wheat
corn
grapes
pomegranates
2 poppy fields located south west of Panjwai Bazaar

4. Abdul Razock, translator from Arghandab, Kandahar province, and Quetta, Pakistan.
Languages Pushtu, Farsi, and English.

Methodology

An 18 page monitoring questionnaire developed by CMC was used as a guide for clinic monitoring. It consisted of three separate sections: 1) Interview of the HCW, 2) Observation of the Facility, and 3) Interview of Resettlement Issues. This questionnaire is available from CMC.

Geographical Area

Originally a two month mission was planned to visit the provinces of Kandahar, Helmand and Zabul. The geographical focus had to be narrowed to include, primarily, the districts surrounding Kandahar City: Arghandab, Maiwand, Panjwai, Dand/Daman. A brief stop at Shahwalikot was also made.

Unfortunate circumstances prompted the change in plans. On the main access road to the entire region of south west Afghanistan, our 4-wheel drive jeep Wagoneer broke an axle. While returning to Chaman for repairs, our vehicle plus the Mercedes lorry carrying it, became stuck and submerged for four days in the swollen Tarnack River. There is no bridge crossing the river. Every year it is impassable in January and February. This year because of heavy rains and the usual melting snow from the northern mountains, it was impassable from January to April. When leaving Afghanistan on April 28, 1989 and crossing the Tarnack, we saw 10-15 large painted lorries still immersed in the mud, with gushing water washing the wind screens and cab interiors.

Method of Transportation

Transportation included a purchased vehicle (used for 1 month), trucks provided by commanders (Mahaz), motorcycles loaned by Solidarite Afghanistan, and our own feet.

Limitation of Scope

Because we were confined to one geographical area, the focus of the mission changed. The problems and issues we saw were more microcosmic in nature, allowing us to give closer inspection to a smaller area. This had unanticipated advantages.

Foods in short supply

corn	cooking oil
wheat	sugar
meat	tea

Farm animals in short supply

Oxen
milk cows
donkeys

Food Storage

Local silo destroyed
No other large buildings repaired
people living in any structures still intact.

Water

Karez and canals mostly destroyed
few canals carry water from Arghandab river.

Wells mostly poisoned or contaminated
by dead animals.

Mines

16 different kinds, mentions:
- antipersonnel
- garnet
- charparkat

Located "everywhere, dumped from airplanes and placed by Russians in"
- villages
- city
- mountains
- fields

Reconstruction priorities

Answer from HCW:
- health
- water
- agriculture

Answer from mujahid:
- agriculture
- water
- roads

Prices of Commodities

Kerosene	100 Af/L	Black tea	900-1000 Af/kg
Sugar	125-150 Af/kg	Chicken (usually not available)	3000 Af/bird
Rice	160-200 Af/kg	Soap	50-60 Af/bar
Wheat	50 Af/kg	Milk powder	400 Af/450g can
Beef	250 Af/lb		
Kerosene	600 Af/L		

Prices of Commodities

	Last year	This year
Rice	120 Af/kg	150 Af/kg
Oil	2500 Af/16kg can	4000 Af/16kg can
Sugar	80 Af/kg	180 Af/kg
Chicken	1000 Af/bird	3000 Af/bird
Tea	600 Af/kg	1000 Af/kg
Wheat	30 Af/kg	60 Af/kg

ARGHANDAB DISTRICT

People interviewed:

Haji Sufi Patou - Mujahid living in Char Bagh, from Myanjoy.
Fathi Mohammad - HCW living in Char Gul Bagh
Abdul Hay - HCW living in Mian Shohin

Char Bagh - Village

Population before war	50 families
Families left since war	100%
Families returned	0
Housing destroyed	100%
Rebuilt	0

Char Gul Bagh - Village

Population before war	1000 families
Families left since war	100%
Families returned	0
Housing destroyed	100%
Rebuilt	0

Mian Shohin - Village

Population before war	300 families
Families left since war	100%
Families returned	0
Housing destroyed	100%
Rebuilt	0

Khwajamolk - Town

Population before war	1000 families
Villages surrounding	15
Families left since war	50%
Families returned	50
Housing destroyed	10%

Town protected from ground firing by mountains
Usuwali center nearby - government post there

Rebuilt	5%

SHELTER

Materials needed for rebuilding not available locally.
Wood (beams, windows, and doors), cement, fuel to make kiln brick, glass, metal for roofs, lime.

Cost - 1 family house
5 Lak/Afg. 3 rooms

POPULATION

Emigrated to:

Kabul:	0	Pakistan:	87% Quetta
Iran:	5%	Afghanistan:	3% Herat
			5% mountains

Population left: 8-10 years ago

Refugees returning:
We saw several tractors pulling trailers with families and household contents.

One person answered 50 families - Khwajamulk
All others answered 0

Comments about repatriation:
"People are afraid to come back because the government troops are still in Kandahar city. One and a half months ago there was bombardment".
"Mujahideen are afraid bombardment will start again".
"They won't be back because they have no money to rebuild".
"They will have to stay in Pakistan until the country is set free".

POLITICAL DIFFERENCES

Preventing return - denied by all who attempted to answer this question. All denied animosity toward those who fled and welcome their return.

EDUCATION

Char Bagh - No schools "only mujahideen are here"

Char Gul Bagh - 1 madrasa/mosque
Swedish Committee providing funds for:
salaries, books, pens, and blackboards.

Mian Shohin - Unknown by interviewee

Khwajamolk
2 madrasa to 9th class
boys only
funds provided by families and Commander Mullah Naquibullah Akhunzada - Jamiat.

FOOD AND AGRICULTURE

Char Bagh
All Aabi land unproductive
Irrigation destroyed
Lack of population to work land
% Aabi vs Lalmi - unknown
jeribs previously cultivated - unknown

Char Gul Bagh

Aabi land 90%	5% productive
Lalmi land 10%	100% unproductive

#jeribs previously cultivated unknown

Comments:
"Grape yards burnt during bombardment".
"People are poor and can not work their unproductive land".
"Many trees died during last year's cold winter".
"There is no reason to work Lalmi land when so much Aabi land is unused".

Mian Shohin
Aabi and Lalmi land cultivated Unknown by interviewees
#1 "I am not from area"
#2 "I am not a farmer"

Khwajamolk

Aabi land irrigated before war 3000 jerib
Lalmi land irrigated before war 2000 jerib

Aabi - potentially productive
- good water source from Zahir Shah canal
- area suffered relatively little bombardment
- no population to work land
- lack draft animals and equipment

Lalmi - unused
- no population to work land
- no draft animals and equipment

Seed

Available in bazaar - poor quality comes from Pakistan.
Some good seed comes from Khakrez.
Some given by Swedish Committee

Kandahar bazaar:
Wheat seed - 1 bag 15-16 man = 3,800 Af.

Fertilizer

Available in bazaar in Kandahar city, comes from Pakistan and Kabul.

White - 11 man	=	2,500 Af.
Black - 11 man	=	4,000 Af.

1 man = 4.5kg

Major locally grown agriculture products

Before war:

crops & vegetables	wheat		tomatoes
	beans (green & red)		spices
	vetch		peanuts
	peas		melon
	spinach		water melon
	potatoes		squash
	cucumber		corn
	"long cucumbers"		leeks
	carrots		lettuce
	onions		
Fruit trees:	apricot	apples	pears
	plums	pomegranates	grapes
	peach	mulberry	lemons
	cherries		

Now: wheat
orchards mostly unattended
two opium fields seen outside markaz in Char Gul Bagh

Foods in short supply

Meat - mutton now available from Kuchi men who have come on seasonal migration.

Enough food available for number of people.
90% imported from Pakistan in winter.
(remember the Tarnak River; no food when it is impassible).

Farm animals in short supply

	Before war # of families with at least one of each animal.	Now # of families with at least one of each animal.
Cows (milk) 103,000 Afs.	60%	15%
Sheep	-	15%
Goat	-	5%
Donkey	-	30%
Camel (Kuchis)	-	20%
Chicken	-	15%

Most frequently mentioned animals in short supply oxen, mules, donkeys.

Prices of Commodities

Kerosene	100-200 Af/L	Black tea	900-1100 Af/kg
Sugar	150 Af/kg	Chicken	1000-1500 Af/bird
Rice	130-150 Af/kg	Soap	50 Af/bar
Wheat	50 Af/kg	Milk powder	400 Af/450g can

Want for future

tractors and ploughs
repair of canals with cement
seeds
agronomists

MAIWAND DISTRICT

People interviewed:
- Uman Jan - Mujahid from Baradzai
- Mohid Wali - HCW living in Mirakora Kala
- Abdul Khi - HCW living in Sang-i-Sar

Baradzai - Village

Population before war	50-60 families
Villages surrounding	50-60
Families left since war	100%
Families returned	0
Housing destroyed	100%
Rebuilt	0

Mira Kora - Village

Population before war	1000 families
Families left since war	100%
Families returned	0
Housing destroyed	100%
Rebuilt	10%

Sang-e-Sar - Village

Population before war 20,000-25,000 families in 40,000 jeribs area surrounding village

Families left since war	90%
Families returned	50 families
Housing destroyed	90%
Rebuilt	0

SHELTER

Materials needed for rebuilding not available locally:
Wood (beams, doors, windows), cement, stone and metal for roofs.

Cost - 1 family house:
10 Lak - mud brick
40 Lak - kiln brick

POPULATION

Emigrated to:

Kabul: 0	Pakistan: 60% Quetta
Iran: 20%	Afghanistan: 20% mountains

Population left: 7-8 years ago

Refugees returning:
One person answered 50 families - Sang-i-Sar
All others answered 0

Comments about repatriation:
"20 days ago there was bombing in Mirakora Kala".
"The refugees will not return until the government falls".
"No one has returned, and will not until Afghanistan gets it's freedom".

POLITICAL DIFFERENCES

Preventing return - denied by all.

EDUCATION

Baradzai
No schools now
Before war: 1 government school to 12th class boys only.

Mirakora Kala
No schools now
Before war: 1 government school to 6th class boys only.

Sang-e-Sar
1 madrasa to 5th class; boys only.
Funds provided by Makaz - Commander Mullah Faizullah Akhunzada-Harakat Engelab for salaries, books, pens, wood.

FOOD AND AGRICULTURE

Baradzai

Aabi land irrigated before war	3000 jerib
Lalmi land	None before war
Aabi land now unproductive	90%

Comments: "no families to work land"
"irrigation is destroyed"
"only mujahideen here now"

Mikora Kala

Aabi land	80% unproductive now
# jeribs previously cultivated	unknown
Lalmi land	None before war

Comments: "bombardment destroyed irrigation"
"no people to farm land, no tractors, or oxen"

Sang-e-Sar

Aabi land	unknown
Lalmi land	unknown

Seed

Available in Maiwand bazaar - "People can not go there because the government will take them".
No local seed available
Imported from Pakistan

Enough seed is available
No one to plant it until the families return.
No irrigation available because canals are destroyed.

Fertilizer

Unknown by people interviewed
"We do not farm now, we are still fighting".

This is a report of our observations. It is by no means an attempt to describe the total health care picture of Kandahar. It represents what we were able to accomplish with limited transportation. We hope the details which unfold in the following pages will give a better picture of health care in the Kandahar area. For specific information supporting general statements, please refer to our Detailed Report.

Mary Dean R.N.

Major locally grown agriculture products

grapes | vetch
wheat | beans
cotton | corn

Foods in short supply

wheat
corn
meat

Farm animals in short supply

"All of them", especially oxen.

Water

Canals from Arghandab destroyed
Need to dig new wells for homes -
water found at depth of 5-6 meters locally.

Storage buildings

None

Mines

Types:
- Kandani
- Charparkat
- Antipersonnel

"numberless" amount
- located in gardens and fields
- around abandoned Russian posts and camps
- dumped from airplanes

Prices of Commodities

Kerosene	200-250	Af/L	Black tea	900-1000	Af/kg
Sugar	200-250	Af/kg	Chicken	1500-2000	Af/bird
Rice	200-250	Af/kg	Soap	50-60	Af/bar
Wheat	50-60	Af/kg	Milk powder	500-600	Af/450g can
Petrol (can)	700	Af/gal.			
Wood	100	Af/man (1 man = 4.5kg)			

Appendix 2

AVICEN

Mahmad Amin Arian
Taj Mahmad Mazlomyar

Both of these men have been trained by AVICEN.

Taj Mahmad is Mullah Gull's mujahid. He has just been trained by AVICEN and is doing his first vaccination campaign.

Mahmad Amin is from Kunduz. He was going to take vaccines to the north, but because of snow the road was closed. Instead of waiting for the road to open, Mahmad went to see AVICEN and told them he was willing to work elsewhere. So it was decided that he would go to Kandahar.

- Left Peshawar on the 23 February, 1989
- Arrived in Quetta and went to Chaman
- Left Chaman on the 3 March, 1989
  Arrived in Khwajamolk on the 4 March, 1989 and the following day we finally reached Sukh Cholla. The refrigerator was started many times during the trip, in Quetta, in the hotel in Chaman, and now in Sukh Cholla.

Installation

We met the AVICEN team on the 19 April, 1989. They were living in Abdul Razock's house near the mosque in Sukh Cholla. Sukh Cholla is one of many villages along the Zahir Shah canal and is about half a kilometer from Khwajamolk on the left side of the canal.

Abdul Razock is Mullah Nakibullah Akhunzada's old mujahid. He used to work with SCA, and now owns his own drug store in Sukh Cholla which he has had for one month. He opened this small shop because it was difficult for him to have a family life, he was not paid enough, and was sent to different places far away from his home. Abdul has been a great "memandor" during the time we stayed there, providing very good and tasty food, speaking in Farsi to us and enjoying the conversation, and also providing a private room for myself and Mary. I think he has been a great help to the AVICEN team, it was no problem for them to stay in the house. He is also a good friend of Taj Mahmad.

Abdul Razock provided a bare room for the refrigerator and material boxes. The room was 3.50 x 5 meters with two windows on one wall, and two windows on the other wall. The windows were closed with shutters and the door was open which let in a fresh warm breeze. In one corner of the room, on the wall opposite the door, was a gas refrigerator (UNICEF). The refrigerator thermometer read 7 C and an electronic thermometer read 0.5 C. In the refrigerator the BCG vaccines were at the bottom, the measles vaccine in the middle, DPTP and TT vaccines on the top. Three or four ice-packs were being made which were stuck along the metalic freezing bar, a space of about 2-3cm was left free to separate them from the vaccines.

Around the refrigerator, boxes could be found which had been placed there when they had arrived. There was 1 spare gas bottle, cartons with single use syringes and needles, and 1 carton with women and children's registration cards. There were also tools and spare parts for the refrigerator thermostat.

Outside, on the terrace near to the toilets, a small corner was black with smoke from burning syringes, vials and needles. They said that they burn these every afternoon, after the work in the morning.

WORK

A. What was done

He said that there was a measles epidemic when they arrived, so measles vaccination was started for children 6 months old (we did not hear of any epidemic, even when we were in Khwajamolk 12 April, 1989). They started the work on 8 March, 1989.

Village	No. of vaccinating days	No. of Children	Children/day
Sukh Cholla	4	371	92
Mazrah Kohna	2	529	76
Gull Kalacha	1	603	74
Odji Tur Kalacha	1	670	67
Sarda-e-Payan	1	787	117
Sarda-e-Bolla	1	906	119
Delawar Khan Kalacha	1	1040	134

We also took their last day vaccination statistics chart for Sarda-e-Bolla on 18 April, 1989. 119 children were vaccinated.

	BCG	Measles	DPTP	Tetanus for females
3 months	6	0	0	from 6 years to 14 years:24
4-9 months	9	0	9	
10-12 months	7	7	7	
13 months - 3 years	41	35	41	
4 years	33	31	34	
Total	96	73	91	

Comments:

A new AVICEN/UNICEF aim is to try and vaccinate as many young women as possible. It is very difficult in Afghanistan to obtain access to the married women, therefore the plan for the next month is to try and vaccinate the women before they have reached child-bearing age. Tetanus is being given to girls under 14 years old, and if we are able to get them vaccinated at least three times, at the best five doses, we could hope for good results. The most difficult time will be the follow up. They were told to come back within 6 months.

DPTP is started at the recommended age: up to 3 months
Measles is started at the recommended age: up to 9 months
BCG is started as soon as the child is born.
TT can be given to mujahideen until the 19 April, 1989.
3 mujahideen have already been vaccinated.

For children 10-12 months, all of them received BCG, measles, and DPTP at the same time.

For children 13 months - 3 years, 41 children received BCG and DPTP at the same time. Only 35 children received measles immunization, as the vaccinators were told that the other 6 children had already had measles.

In a mass campaign, you never listen to what the people say! Vaccinations are carried out according to the immunization program, in a "blind" way. Who is the doctor around that would have the knowledge and capability to certify that a child has had measles?

As there is no contra-indication to re-vaccinating a child who has already had measles, to keep a safe level of immunized children among the population, the policies all around the world are to vaccinate "blindly".

<u>For children more than 3 years old</u>,

- 33 BCG
- 34 DPTP

A child had already been vacinated in Kandahar City. It would have been interesting to test the quality of this vaccine which is made in Kandahar by the governmental programs. A way it could have been tested would be to give the child a half dose of BCG, and have him come back to check the cutaneous reaction.

B. Registration:

The registration system appears to be working quite well. Avicen provided them with a register and a chart to detach from the book. This green paper then stays in the hands of the village representative (mallem, mullah etc.) The chart is proof for anyone who vaccinates the children, to tell who has already been immunized. The only problem is that on the 20 April, 1989 they forgot to use the carbon paper in the registration book.

Vaccination cards have a different color for boys and girls. The idea is a good one for parents who cannot read as they can understand whose child the card belongs to.

C. Transportation:

The journey from Quetta to Khwajamolk had problems with difficulties crossing the Arghandab River, (as everyone had that season), moving themselves and transporting the vaccines. They brought a Yamaha 100cc which cost 180,000 Afg.

On the evening that we arrived, Taj Mahmad had gone to Mohmad Yakub Kallacha, which is a fifteen minute drive from his home, to tell people that we were coming the following day. This was effective as when we arrived the next day, three fathers were waiting for us on the other side of the bridge.

D. Salary:

An AVICEN vaccinator is earning 1500 Rs./month. If he is not working in his woleswali, he gets 500 Rs. more (Mahmad Amin).

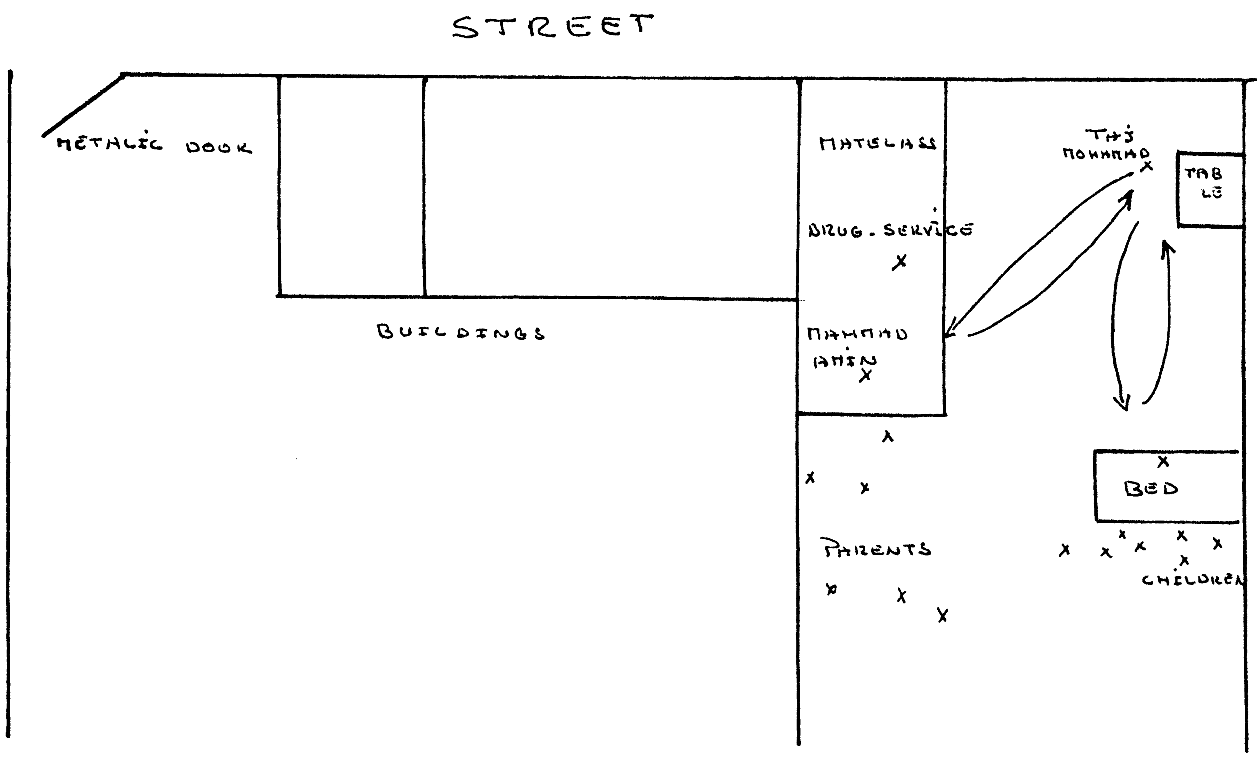
E. Vaccinators Performance

20 April, 1989 - Mahmad Yakub Kallacha

Arriving by motorcycle at the village around 8am. Taj Mohmad seems to be known and fixes everything. He chose to work in an open-air hanger, which had mud walls on 3 sides, and one left open like a garage. The mud roof was approximately 2 meters high, there is little breeze this morning.

An old man with his child asks if the vaccine is for a common cold.

ORGANISATION PLAN



The instruments were all carried in a tissue bag along with a register they will need.

An ice pack was on the table with the following:

- BCG is being prepared.
- Measles and DPTP are also on the ice pack
- The opening date is written on the bottles
- The BCG is not protected from the sunlight.
- Dettol will be used as antiseptic, except for the BCG, when no antiseptic will be used.
- Taj Mohmad is preparing.

During this time Mahmad Amin, after searching for his carbon paper which he had forgotten, writes on his registration book and prepares the vaccination cards. He also tells people that fever can occur.

While Mohmad gets the card written, M. Amin is 3 meters away from the table. After this, he calls the child and looks on the card for what kind of vaccine he has to inject. Generally, the BCG is given in the upper left arm. The measles is given on the right arm using Dettol as antiseptic, and DPTP in the buttock. When the children are called they come near to the bed which is 2 meters away from the table.

No syringes are being filled before the child is called. The bevel point of the BCG needle is the first part to be carefully put through the skin. DPTP is done in profund intramuscular injection. The dilutions are correct. The remainder of the doses are put back into the exact corresponding vial.

There are some problems in estimating the children's ages. Mahmad Amin writes "one year" for a child who is obviously two years old. On the vaccination card, the BCG date is written. The DPTP is written underneath, so if they do it the same day the date is not fully written.

A third person is being employed to dispatch the Paracetamol. As they are running short of Paracetamol, the parents or children only receive it on request. The Paracetamol had been sorted into individual doses the previous day, and put into plastic bags which are remaining from the syringes.

One hour after the beginning of the work, the vaccine carrier sat on the ground. Near to the table the thermometer read +4'C. I think the wooden thermometer inside is not appropriate.

We say "goodbye" and wish them success with their work.

Recommendations:

Public Health (census)
Posters not used
Mujahideen vaccinated.

Appendix 3

KHWAJAMOLK BAZAAR PHARMACY

I. CLINIC IDENTIFICATION

Location   Khwajamolk, Arghandab

II. Personnel

Noor Mahmad : Male 28 y/o: Alikozai
s/o Fazel Mahmad   Pashtouns - Farsi
Brother of Gull Mahmad - MSH

- Shop built 3 years ago
- Used to work with Doctor Sayed Ahmad who left for Pakistan 11/2 years ago.
- There are now alot of Doctors around and everyone is writing prescriptions. He is doing more work than he was a few years ago.
- Relationship between knowledge and medicine supplied: They say they know more drugs than they are supplied with.

Medicine Supply: From Pakistan: He brings them himself
From Kabul: He pays an old man to fetch it for him - 5000 - 6000 Afg/day.
From Kandahar City: Very few.

Drugstores in Khwajamolk:

There are three other drugstores in Khwajamolk.

1. Kalender's drugstore.
2. Raz Mahmad's drugstore.
3. Molla Sahib's drugstore.

II. KANDAHAR: THE HEALTH CARE WORKER AND HIS ENVIRONMENT

General Conditions in Kandahar

Kandahar is brown and arid with the orange desert stretching as far as one can see to the south, and barren mountains rising in the north. Most of the karezes and canals have been destroyed, but wherever there is the slightest bit of water, lush green growth is found. One can imagine the vineyards, fruit orchards, field crops, and vegetables which were the main economic resources of Kandahar. Vineyards and orchards that were not bombed or burned are standing, but are mostly unattended, due to lack of manpower.

Village after village is in rubble, inhabited only by shaghals (jackals), bats, owls and English sparrows. Some remnants of the typical Kandahar architecture, with high curved intricate brick work ceilings can still be found. Here and there a few family flower gardens have survived, with a wide variety of roses and ornamental bushes attracting many colorful birds.

A few refugee families were returning to Kandahar from Pakistan.(1) Tractors pulling trailers piled high with household items and animals tied to the top, were making the tedious trip from the camps around Quetta.

The families that have remained during the war tell, with gnawing grief, stories about the mortifying and desperate lives they have led. There are still daily reports of antipersonnel mine casualties. Fighting is continuing between the government troops and the mujahideen, mostly at two sites: Kandahar city, and the airport 10 km to the south.

Local Health Care Providers

A collection of local health care providers with different skills was identified as the mission progressed. These groups will be elaborated within the Detailed Report, but are listed here as follows:

- Dais (traditional birth attendants) (2) (3) (4)
- Shekestaband (traditional bone setters)
- Barbers (circumcisions)
- Teb-e-Unani (doctors using plants and herbs) (5)
- Dawa khana (pharmacy)
- "Doctors" with no formal training
- Trained HCWs
  - 3 - 18 months non-governmental organization (NGO) training
  - Afghans with pre-war training

<u>Drug List:</u>

Recresal Tonic	Hoecht	Afg
Atarax	"	"
Sedetab (=paracetamol)	"	"
Baragil Drops	"	"
Hostacyclin Tab (Tetracycline)	"	"
Novalgin Tab	"	5Afg/Tab
Novalgin Amp	"	"
Baralgin Amp	"	"
Avil Amp	"	"
Ampicillin 500mg Tab	10.3 Afg/Tab	
Promel Sexual Tonic Tab (1 months supply)	German	bought in Pak.600 Afg/each
Procomil Sexual Tonic Tab (chewing Gum)	"	" " " " " "
Retardex Sexual Tonic Tab (Chewing Gum)	England	" " " " " "
Promise Sexual Tonic TAb	Australian	" " " " "
Molton Syrup		
Becozym (Roche)		
Actifed Syrup		
Germafin (Laxative)		
Vit D Compound Tab		
Ampicilline Syrup		
Ancebagol Syrup		
Phospholecithin		
Incremin B Complex		
Mosegor (Sandoz) : Appetite Stimulant		
Unani Syrup of Doctor Faulad : Appittie Stimulant		
Simeco Syrup (Wyeth)		
Cotrim Syrup		
Ampicilline Syrup (Goaf)		
Stepto Magha Syrup (for Diarrhea)		
Surbex B Complex		
Chloramfenicol Syrup (China)		
Surficol (Cough Syrup)		
Proguine (Chloroguine Syrup)		
B.G. Phos.13. Complex Syrup		
Digelex Syrup		
Piperazine		
Ephedrine Compound Syrup		
Bactrim Syrup (Roache)		185Afg
Calpol Paracetamol Syrup		
Oxtetracycline Tab		1.5 Afg
Azmagel (Antacid)		
Avil Ointment		
Hyscopan Vial		
Geomycian (For children's temperature)		40Afg/vial
Bypiron Vial (metranizol)		

B Complex Vial	
Vit B6 Vial	
Chloroquine 5ml Vial - 40 mg base - 65mg/ml	
Avafortan Tab	20 Afg
Calcium IM	
Vitamin C	
Nocares Children	
Pronapen	70Afg/Vial
Penicillin V	50Afg/12 Tab
Skilax (Laxative Drops)	
Valium 5mg Tab	
Metronidazole	
Cotrimoxazole 400 mg Tab	5Afg
Furadantin Tab	
Avil IM	
Griseofulvin Tab	
Buscopan Tab	12Afg
Lasix Inj	
Novalgin	
Vit K3 Inj	
Multivitamin Tab	
Neurobion 13 Complex	
Erythromycine Tab	15Afg
Aldomet Tab	
Chloroquine Tab	2Afg
Coldene Tab	
Asprin Tab	2Afg
Hyoscine Tab Inj	
Ibuprofen Tab	
BP Cuff	
Stethoscope	
Actified Tab	
Eye drops	
Ampicillin Inj	
Indomethacin Tab	
ORS	
Streptomycin Vial	40Afg

Appendix 4

Interview with Dr. Guy Zimmerman, February 5, 1989, Quetta, Pakistan.
Deputy Coordinator
International Committee of the Red Cross[1]

An interview with Dr. Zimmerman was prompted by reports that ICRC was planning to establish a hospital in Kandahar City. Dr. Zimmerman tells us that, in fact, this is not so, because the Kabul government was reluctant to give permission due to continued bombardment in the area.

There were also plans for a clinic in Khwajamolk, with one expatriate nurse and three other HCWs. This idea has also been abandoned due to continued strife.

ICRC operates three hospitals to treat war wounded in Kabul, Peshawar, and Quetta. The Quetta facility has 150 beds, with an extended bed capacity of 300 beds, if needed. The current staff includes 5 surgeons, 3 anesthetists, 4 expatriate ward nurses plus lay nurse assistants.

A Saudi hospital located between Chaman and Quetta is the only other Quetta based hospital receiving war wounded. It is a medical/surgical hospital with a 100 bed capacity.

ICRC also operates first aid and border evacuation sites to transport the war wounded. They function with the permission of both advisaries and are politically non-aligned. In the Kandahar area, these sites are located in Chaman, Badni, and Dalbandin.

Chaman is the largest facility and operates with an Afghan physician who does some simple surgery. Mostly, they stabilize and transport. Chaman has a 25 bed capacity and 3 ambulances.

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1 McKenzie, Evan, Morris, David, Suqrue, William. "On The Border of Afghanistan with the International Committee of the Red Cross," 1985.

The Badni facility consists of one nurse and helpers, 10 beds, and one ambulance. It receives most of the war wounded coming from the Kandahar area. Badni is located far north of Quetta. Chaman would be the logical evacuation site, but cannot be used because of the presence of a government post in Taktapul, which is located on the main Kandahar/Chaman road. The use of Badni site causes much delay in travel time, as the ambulances are forced to swing far to the north before dropping south to Quetta.

Dalbanden receives the fewest casualties. The staffing and capacity were not mentioned. It has one ambulance.

Plans for the future

Dr. Zimmerman mentioned no concrete plans for the future. He had recently arrived in the country and could only say that most all plans were "on hold" until ICRC could more clearly access the developments between the Najibullah government and the mujahideen.

Appendix 5

Dr. Ibrahim Balouch Interview: A Surgeon With No Formal Training

Dr. Balouch
aka Mohammad Abrahim s/o Mamoud Assif
Present location: Nakhuni, Panjwai
Tribe: Baluch
Comes from: Nadali, Nimroz
Party affiliation: none
Commander: none
Committee support: none

A visit to Dr. Balouch was prompted by reports of his doing frequent amputations. In fact, he is the renowned "surgeon of the Kandahar area". He is well respected by the community and has a "thriving practice".

History

He says he came to Kandahar from Nimroz because he had many enemies in the area, as a result of his fighting against the government. He further relates that he was told to leave the village because the people felt it would be bombed if the Russians knew a doctor was there.

Background experience as related by Dr. Balouch:

- Attended Dar Ulaman nursing school, Nimroz (?).
- 1 year before the war worked in a police jail as a surgeon (Kandahar City).
- Jailed for a few months (location undisclosed).
- Came to Arghandab - Malajat area, worked with the mujahideen as a mobile doctor and has been here for 8 years.
- Used to work near the Mullah Malang clinic (Nakhuni, Panjwai), but moved because the house was not his own. This is his first clinic, 10 minutes motorcycle ride from the Mullah Malang facility. He built the house and clinic himself.

Background experience as related by others:

One prominent former Kandahar resident remembers that before the war Dr. Balouch was working as a sweeper in Dr. Sayed Mir Jan Shaheedi's office. The doctor taught him to give injections, which was the beginning of his medical career.

A local graduate medical doctor remembers that Balouch was a drug injector in Kandahar City, who moved to the village and set himself up as a surgeon.

Clinic

The clinic consists of one small mud brick room attached to the outside of the family compound. One steps and bends, at the same time, to enter through a short door into a small, dirty, musty, and very dark room. Canvas covers the floor, and furnishings consist of: one desk, two toshaks, one cabinet, four wall shelves and medications stored in cardboard boxes on the floor. A thick, long, black, rubber tourniquet sliced from a tire inner-tube and caked with dried blood, was the only wall decoration. A small alikin (gas lamp) was the only source of light.

We sat on toshaks facing a dark, small framed young man, with a haggered looking face and piercing eyes. His affect was flat and his manner nonchalant (possibly because we had just awakened him from a nap). There was barely room for the five people sitting down, when two children piled in the room along with another man, his chest loaded with ammunition belts. Now, there was no floor space left. We could just imagine the scene during surgery.

Support

Haji Habibullah (aka Abdul Khylose), the local khan from Sal-e-Khan, "is a very rich man and gives money to pay for everything". "He has people working for him in Arabia". Every three months, Balouch receives 20,000 - 30,000 Afgs. from Khylose.

Medication supply

Haji Abdul Khylose gets a list of drugs from Dr. Balouch and takes it to the Kandahar bazaar. Khylose then arranges for the drugs to be delivered to clinic where Balouch pays for them with money given by Khylose.

Last drug delivery included:

Antitetanus serum	Dextrose mix
Saline serum	Plasma
Vitamin C ampule	Novalgin
Avafortan	Baralgin
Atropine	Nikethamide
Torecan	Chloroquine
Regasil	Aqiplex
Metaclopramide	Xylocaine
Sutures	Hydrogen peroxide

Assistants

Two assistants trained by Dr. Balouch:

Abdul Rashid - no formal training

Abdul Halim - attended an eighth month training program at Shahid Lala Malang hospital, Quetta. Left after 7 months without receiving a diploma.

Description of activities

Dr. Balouch tells us he sees 20-40 people each day for consultation, approximately 10% of these patients are women.

Interview quotes:

"If the war starts again possibly 20 patients will come each day, 19 will need leg amputations and one will need a hand amputation".

"Six years ago 17 people came after a mine blast. Twelve died from lack of medicine".

"Last month 3 people died in the clinic. Two because of lack of transportation to Pakistan, and one from a bullet in his head".

Last week, Dr. Balouch says he did four amputations, one foot and three hands. All of these were mine injuries. He also removes bullets, and does incision and drainage of abcesses.

Major local health problems

The major local health problems he says he treats are cholera, diarrhea, malaria, and abdominal pain because "the people eat too much potatoes and bad food".

Description of preparation for amputation technique

Dr. Balouch operates day and night, "whenever the patients arrive". As noted before, he only has one small gas lamp for light. He works with the two assistants mentioned above. A leg amputation takes 45 minutes.

Before performing an amputation he gives:

- 1 Plasma infusion with calcium, 1 Dextrose infusion with Ampicillin plus Vitamin C.

- Gives Sosegon direct IV push to "put the patient to sleep".

- Injects Xylocaine around area he is going to amputate.

Instruments

Instruments, displayed for our examination, were taken from a mud covered briefcase. The instruments were purchased in Quetta with his own funds.

2 metal saws	1 large file
2 fork retractors	1 large black rubber tourniquet
1 large hemostat	2 small hemostats
2 finger cutters	1 large abdominal forcep (retractor)
1 set: scissors, hemostats, scalpel handle and blades.	2 medium abdominal forceps (retractors)
3 skin retractors	3 organ retractors
3 large forks	2 gauze holders
1 ear syringe	2 sets otoscope-ophthalmoscope
1 set of dental tools	

Sterilization

Dr. Balouch describes his instrument sterilization technique while spitting naswaar over his instruments, into a spittoon. As he speaks, his plays with the contents of the briefcase with his grimy hands.

To sterilize instruments he:

- boils for 10-20 minutes
- wraps instruments in a cloth
- places in briefcase

He has no sterile dressing material.

Examples of medical treatment

Since there were no patients present, we asked Dr. Balouch how he recognises and treats the following diseases:

Cholera

DX: fainting
diarrhea without blood
pustules over the whole body, with and without water.

RX: Sodium serum
Torecan
Vitamin C ampule
Baralgin ampule
Buscopan
Hyoscine ampule
Sulfaguanadine
Chloranphenicol syrup
Vitamin B complex syrup

Leishmaniasis

DX: "The skin disease of syphilis"

RX: Washes the body with Benzyl Benzoate, then Savlon.
Applies Dettol lotion to the whole body.
Gives:
Optilets syrup
Towalgin (not in QIMP)
Zemoflex " "
Longifene
Calcium Sandoz ampule
Calcium Gluconate ampule
If constipated gives Magnesium Sulfate.

In the Mullah Malang clinic, Dr. Jabar received a patient from Dr. Balouch who was seeking further consultation because his condition had not improved. The 45 year old man had been coughing and producing blood for 10 months. He was bearing three previous perscriptions written by Dr. Balouch:

#1 RX: Calcium Sandoz ampule
Detol
Procaine Penicillin ampule
Vitamin B complex ampule
Novalgin ampule
Hemosil syrup
Vitamin K ampule
Carnogin drops (not in QIMP)
("Antihypertensive")

#2 RX: Serum Physiologic
Novalgin ampule
Vitamin B complex ampule
Hemosil syrup
Procaine Penicillin ampule
Vitamin K ampule
Calcium Sandoz ampule
Carnogen drops

#3 RX: Rifampicin #90 - 3 caps/day
Multivitamin
Ventolin syrup
Ludiomil tablets
Streptomycin 1gm #10 ampules
Myconizol ointment (not in QIMP)

We also saw an 8 year old female who had undergone a Balouch amputation of the fingers of her right hand four days before. She had come to the clinic (with her mother) for dressing changes and post operative care. The child had picked up a toy-type mine which exploded causing destruction of the tissue and bone of all her fingers (extent of damage unknown).

The fingers had been amputated to 1cm above the 1st joints. The remaining bones were covered with sutured skin flaps. The HCW at the Mullah Malang opened some of the sutures and expressed a large amount of prulent drainage. The hand above the wound was grossly edematous, reddened, warm, and very painful. There was no sling or other means of elevating the hand. A drug therapy given at the Lala Malang clinic is unknown.

Desires for the Future

Dr. Balouch states that he wants to build a "real hospital", if he can get help. He also mentioned twice, that he wants a woman doctor to help treat the women patients. Balouch further requests an ambulance.

This man was proud of his accomplishments and seemed entirely unaware of the incredulity of his rise from sweeper to surgeon. He spoke in a direct and unabashed manner answering all our questions freely.

Comments

Lacking other options, people create their own health care systems in response to what they believe they need. Dr. Balouch is a product of this process, adequately supported with funds by the community, and well supplied with a plethora of drugs from the bazaar. He has stepped into the scheme to fill a need.

- Graduate MDs located in:
  - Meir Weiss Hospital
  - Government Hospital
  - Kandahar City -- private practice
  - Clinics
    - 1 American Mercy Corps International (MCI) sponsored (Afghan MD)
    - 1 Arab sponsored (Syrian MD)
- Mullah (traditional role)

<u>Environment/Social Pressures Affecting HCWs</u>

People create their own systems to satisfy their perceived needs. There are as many solutions as needs, and Afghanistan is no exception. A well established traditional health care system operates according to proven methods which work for the Afghan community. (6)

The health care worker must respond to the community's concept of health, which is a passive one in rural Afghanistan. One "gets health" by taking something. Health is an injection, sharbat (syrup) or a tablet; "A good doctor gives good drugs." It is not the active concept that health is something which is maintained and preserved in order to prevent sickness.

The process of an individual seeking health care follows another social pattern which affects the HCW. A clinic worker rarely sees a "first hand" patient. For the individual, the patterns of solving health problems are well rooted in centuries old traditions, except for the recent entry of the NGO-trained HCWs.

Most people with headaches go to the bazaar and buy aspirin. If a person does not understand the medical problem or does not know which drug to buy, he asks his family members or friends. If they do not understand, or if he does not get better, he seeks advice from outside sources, (eg. a mullah or HCW), who may or may not be formally trained.

If the patient chooses to seek the care of a trained HCW, the HCW has the following options:

He can:

- consult with the patient and prescribe drugs from the clinic or bazaar
- refer to another clinic in the area which has a graduate MD, a better supply of medications, special equipment, or a specialty service, (eg.circumcision).
- refer to traditional HCWs (shekesteband, barber, rarely dais).
- or refer to Pakistan (mostly Quetta)

It seems he will have no motivation to integrate himself into an ordered health care system (until in the future he is forced to compete with it). He enjoys his independence, relishes his prestige, is confident in his abilities, and is able to sustain himself financially.

The eradication of such "doctors" will be a difficult task, if possible at all, since they have existed since prewar days, and are well established. Possibly , through education of the local Afghan authority figures, these leaders can come to understand the risks affecting the people of their local communities. Also, if other trained and well qualified HCWs are available locally, the people will at least have an alternative to untrained "doctors".

Appendix 6

KANDAHAR AREA HOSPITALS AND HEALTH CARE PROVIDERS

Information gathered from conversations with Dr. Shah Wali, February 6, 1989 (left Mir Weiss hospital one year ago), and Dr. Wahed February 4, 1989 (left Mir Weiss hospital 3 months ago). Both are currently working with Mercy Corps International (Quetta).

Hospitals in Kandahar City

Afghan Government Hospital

- Located east of the city, on the main road leading north to Kabul, between Kandahar city and Daman city.
- A military surgical hospital for government personnel.
- Some women and children can visit.
- Staffed by Afghan medical doctors.

Mir Weiss Hospital before the war:

- Previously a medical and surgical hospital.
- 250 beds
- 23 physicians
- 3 operating theaters
- 2 women doctors (now in Kabul).
- All specialty areas including ENT, Neurology, Cardiology, Orthopedics, Obstetrics and Gynocology.
- Nursing school for men and women, 3 year program, 10 in each class.
- In 1980 28 female nurses were working in the hospital.
- Hospital was built by the Chinese (date unknown), they left at the beginning of the war.
- The hospital was built on the site of an old farm, a quiet and idyllic spot with many gardens and trees.

Mir Weiss Hospital during the war and now:

- Dr. Wahed, said that 3 months ago there was one medical doctor. This doctor performed no surgery but worked in the polyclinic.
- Local reports gathered during the mission, and contrary to information gathered in our interview, revealed that three doctors are currently employed at the facility:
  - Dr. Sayed Mahamad Rasul
  - Dr. Mahmad Ashem Azikozay - Surgeon
  - Dr. Mahmad Ashem Herati

- Male nurses, number unknown.
- Two women health care workers for deliveries and clinic work.
- In-house patient facilities and supplies for 5-6 beds.
- No nursing school.
- Supplied by the government
- Women and children are being seen.
- Occasionally mujahideen can visit incognito.
- The Hospital is barely functioning due to theft of equipment and bombardment. A large fire in a major storeroom destroyed most of the supplies. The major walls are still intact.
- 90% of the staff was non-government aligned and worked surreptitiously with the mujahideen.

Anecdotal information from Dr. Shah Wali who worked as a surgeon for 6 years at the Mir Weiss facility:

He visited the mujahideen at night to render treatment whenever he was asked. He could operate at night on the mujahideen at the hospital, but they had to come disguised. They trimmed their beards, changed their names, dressed to look like civilians, and came in the company of women. Only those unknown by the government officials could visit, otherwise, they would be captured. Women could go without any problems. Many women are still visiting, in fact, the Mir Weiss hospital is now one of the main sites in Kandahar rendering health care to women.

Before leaving, Dr. Shah Wali had many problems. The government did not supply enough medications and supplies. Since medical doctors from Kabul refused to transfer to Kandahar, there was not enough medical staff to handle the patient load.

He was forced to perform most of his operations using spinal block anesthesia. For general anesthesia, he had to use ether dropped on a mask covering the patients face, there was no other general anesthesia available. Dr. Shah Wali worked with a nurse assistant who had received six months anesthesia training in Kabul. Dr. Shah Wali was not confident in his abilities and therefore could not trust him.

The assistant would check the blood pressure, pulse and pupils as the doctor continued surgery. When doing abdominal surgery, the surgeon had to regulate the amount of anesthesia by observing the color of the blood seen while operating. "When it turned black we gave more oxygen and less ether. It was very difficult, but the only way". The lights had to be dimmed to avoid discovery of the fact that he was operating on wounded mujahideen.

Medicine Supply

- Medicines had been coming from Kabul, very few from Russia, mostly from India, France, Germany, Switzerland and Ireland.
- After the war began all medicines became plentiful in the bazaar and could be purchased easily. Those from the government were in short supply.
- Dr. Shah Wali says that before the war, the selling of medication was strictly controlled by the government. No one could get sophisticated medications without a prescription from a medical doctor.
- Pharmacists had to be registered with the government, and had to have their locations approved to avoid duplication of facilities. These pharmacies were checked by medical doctors to ensure that they were operating according to government standards and selling the appropriate drugs.

Kandahar City Physicians

The following list of doctors was mentioned to us during our discussion with the Kandahar physicians. The exact nature of their medical training is unknown. Mostly women patients are seen by these men. Mujahideen cannot go into the city because of risk of capture or death. Sometimes these doctors leave the city at night to treat the mujahideen.

Gulam Mahmad Malezai
- Located in the De Khuaja area of the city
- Age 65 years old
- Educated in India
- Retired military medical doctor
- Works privately from his home

Anwar Sher Zaed (aka Zan)
- Located in Kiptan Madat Chowk area of the city
- Age 65 years old
- No diploma
- Retired
- Occasionaly works privately from his home

Noor Ahmad (aka Mal)
- Located in Kabul Bazaar
- Age 55 years old
- Has a pharmacy and does consultations

Mohammad Ibrahim Agha (aka Ibrahim Assan)
- Location unknown.
- Age 38 years old.
- Works for the police taking care of personnel.
- Dr. Shah Wali says he is "an honest man, a good medical doctor, and not a party man".

Mohammad Rafi
- Located in De Khuaja area of the city.
- Age 36 years old.
- Government military medical doctor.
- Dr. Shah Wali says "he is not a party man though".
- Mornings he works at the military hospital, afternoons he works from his home.

Khuja Mohammad
- Age 65 years old.
- Medical abilities unknown.
- Believed to be previously a government military doctor, now operates a bazaar pharmacy.

Information gathered from local sources

Shah Sahid Miazai
- Age, location, and training unknown
- Has a pharmacy and does consultations

Ghullam Dustaguir
- Age, location, and training unknown
- Has pharmacy and does consultations

Mahmad Rafi Ammid
- Age, location, and training unknown
- Has pharmacy and does consultations

Abdullah
- Age, location, and training unknown
- Has pharmacy and does consultations, and operations

Said Rassull
- Age, location, and training unknown
- Does consultations and operations

Jahanguir Joy
- Age, location, and training unknown
- Dentist

Sultan Mahmad Kanewal
- Age, location, and training unknown
- Veterinarian

Pharmacies

There are approximately 30 pharmacies located in Kandahar City.

DR. JABAR - INTERVIEW

March 17, 1989

Salawat: Village extended, (more that 50 houses) not damaged very much by the war.

Dr. Jabar is living inside the village in a rich field-owner guest house. The proprietor of the house is living in Pakistan and is not asking for compensation.

An inside garden is enclosed by mud walls and inhabited by 2 rabbits, 2 partridges, 1 pintade, and few hens and the doctor's children. In a corner 10 meters from the house, a latrine is used by the children. A well is 3 meters from the veranda and a women's building and kitchen. This is the only well seen with a tap on it.

His brother and his wife were present too. His brother is tall, young and educated too, but certainly not as bright as Dr. Jabar. He was very busy as he was getting married within 10 days. Their parents are dead.

Jabar's Personal Profile:

- Graduated from Kabul Medical University in February, 1978.
- Was incorporated as a soldier for 10 months.
- Followed a Public Health administration course for 8 months in Kabul.
- Went on a 2 month trip to Hungary to work in eastern hospitals. He was pleased about this journey as he learned a lot and was surprised to see all of the facilities a hospital can provide.
- Came back to Kabul where he was teaching in the medical college until 1985.
- Was sent to Kandahar as the head of the Chinese hospital.

Life in Kandahar

Work with the government: Two years ago he was the head doctor of the Kandahar City hospital. He had personal problems with the Kandahar governor and left the hospital to open a private consultation service in the bazaar.

He says he earns:	Rs. 500/mo.	at the hospital
	Rs. 10,000/mo.	in his consultation
	Rs. 5,000/mo.	under MCl contract

During his work at the hospital, he relates, as do other doctors from Kandahar City, expatriated in PK, the frequent incursions of the party 'police' in the hospital. These police sometimes use violence to take patients from the operation room. During his stay in Kandahar City, Dr. Jabar was constantly overseen from the governmental part.

Work in Kandahar City As he was at first pro-communist, he was looked upon badly by the mullahs and religious persons of Kandahar City.

Contacts with Mullah Malang

Mullah Malang's people got in touch with Dr. Jabar. They extended an offer to him to come with them and work in their clinic for the Afghan population. He then asked if he could see and talk with Mullah Malang. In Kandahar City Mullah Malang has a strong reputation of being a fierce killer. When they met each other, Dr. Jabar believed that he could work with him, in fact, both of them are educated people, English speaking, good looking and certainly have many common points of discussion. In December, 1988 Jabar fled from Kandahar City and came to work at the MCI hospital.

Life in Salawat

In his Salawat house, he is living with:

- His young brother
- His wife
- 1 son 7-8 years old
- 1 son 13 months old
- 1 daughter 10 years old

As he has no fields and no cow, the neighbours are providing him with "dugh" (resembles skimmed milk), not butter. Every morning he goes to the hospital by motorcycle, which is a 15 minute drive away. In the afternoon, a few villagers come to his house for consultations. All of his friends are in Kandahar City or Kabul.

It isn't easy for him and his wife (she only speaks a little Pushtu) to live in a village without any facilities around, as they had both grown up in big cities.

Jabar's Future

Now he wonders what the Russians brought to his country except blood. He does not want to go to Pakistan, but is really waiting to be able to work again in Kabul.

CCL

He is the only real doctor we saw during our monitoring mission in the Kandahar area. It appears to us that his capacities are not fully employed. If he could start to plan a vaccination campaign around Panjwai for the women and children and train his wife to do deliveries, so that she could then train the dai's, maybe his interest in the villagers would make life easier for him and his family.

SCA/School

This was supposed to be a suggestion to SCA to help this woman establish a school.

Doctor Jabar's Wife   Salawat, Panjwai   17/3/89

Sabera

Teacher:	Geography History Mathematics Grammar Ortograph Religion
Has worked:	1 year in Baghlan 6 years in Sha Ahahid School - Kabul 21/2 years in Kandahar 4 months unemployed
Education:	12th Class
Address:	Salawat/Punjwai C/O Doctor Jabar
Salawat:	300 to 400 houses Small amount of damage from war activity Most of the fields are still productive.
Languages:	Farsi Pashtu (some) English (little)

In this manner, the patient typically accumulates many little bags of drugs along his path. Sometimes he continues to take all of the medications simultaneously, especially if he fails to tell the HCW about the past treatments. Sometimes the HCW does not ask about past treatment, and HCWs routinely lack adequate reporting for follow up. This is also complicated by the fact that often the patient does not understand why he was taking each drug in the first place. Diagnosis and directions are rarely written down and do not have much value in a society with high levels of illiteracy.

Environmental/Political Pressures Affecting the HCW

The HCW also finds himself caught in the interplay between mujahideen commanders, who use aid and health care as tools in their struggles for political control. The offering of services to the local community increases prestige. A commander can:

- Dictate the type of services and to whom they will be provided. For example, he can demand that only party members be seen, or that no women can be seen in his clinic(s).

- Choose clinic locations with regard to political aims and desires rather than population or community needs.

- Allocate political party funds and nongovernmental organization (NGO) monetary support to fulfill political goals. The potential for witholding money for salaries and clinic expenses forces the HCW to carefully consider the commander's bidding.

- Distribute or pool supplies in areas that serve their political interests.

The HCW further finds himself ensnared in conflicts between new heads of power (commanders - the military authority model used by NGOs to implement projects), and the traditional tribal heads of power. Traditional power is based on land ownership (wealth), and strong religious and tribal affiliations. Frequently, the commanders have risen to positions of authority and influence as a result of the war effort.
They are relative newcomers, bearing money from their parties and from NGO funded projects. Many of these men own no land locally.

Usually, the tribal authorities do not have the same degree of economic support, because party allegiances are often not as strong as tribal bonds. They are generally overlooked and unidentified by the NGOs, due to lack of expatriate information and understanding regarding local politics inside Afghanistan.

Appendix 8

OBSERVATION OF A SHEKESTABAND PRACTICE

I. Introduction

On March 25, 1989 at 9 pm, the CMC monitors were in Zalakhan having tea and letting the day end.

- Suddenly a mujahid from the markaz entered the room: "Dik sha, Dik sha, mariz shta!"

- We got up and went to Abdul Hakim's clinic.

- Abdul Hakim (MSH) is Fazluddin Agha's (Mahaz) health worker.

- In the clinic room, lit with an electric bulb two wounded patients were lying. The HCW who was making a dressing. Fazluddin's father and two of his sons were also present.

- At the opposite side of the room, a woman was lying down by herself.

- Both patients were coming from Kandahar City where they were wounded.

- We left Abdul Hakim and his spectators with the wounded and moved over to see the woman, who was approximately 27 years old and strong.

- She had a large profound wound of the thigh. Her face covered, she let us suture her wound:

  Deep sutures with catgut, Skin sutures with Abdul Hakim who came after having fixed the man's broken arm. The man had his right arm fixed by a sling bandage. We closed the wound together, leaving a small orifice for any secretion to flow away.

II. History

- March 25, 1989 at 4pm mujahideen around Kandahar City were bombing parts of the city, as they do every day. Mullah Bahahuldin and his wife got shelter in their house inside the city. Suddenly their house fell in on top of them.

- During the time in Zalakhan life is quiet. When Fazluddin Agha's brothers learned that Mullah Bahahuldin was wounded they jumped into their jeep and drove to retrieve him.

- Mullah Bahahuldin is a well known mullah from the city. He also was one of Fazludin's brother's teachers.

- The car came back at 9pm.

III. Shekestaband's Reputation

"But how are you going to fix his broken arm?"

"The shekestaband will do it"

"When?"

"Tommorow"

"Who is he?"

"Odji Akub"

"Where from?"

"He is a very good man from Sabeka China. He will fix the arm, he has already fixed Ashem Agha's leg!"

Ashem Agha is the middle brother of Fazludin's family. He was wounded in his leg during an exchange of gunfire with Governmental Forces. He stayed for 4 months in a hospital in Quetta. When he came back to Panjwai he was still too handicapped to walk. Odji Akub came, fixed the leg with one of his bandages, and 25 days later Ashem Agha was able to walk. He still has 5cm lacking on his right leg, but it still doesn't prevent a mujahid from fighting, does it?

IV. Performance

- On the following morning, Odji Akub arrived.

- He is about 60 years old, coming when people need his services, self-trained and working for 35 years. He showed me a small note book where every commander he had been working for had put his stamp on it.

1. Cleaning the wound:

The mullah and his wife had been sleeping in the clinic. Both of them looked fine. Abdul Hakim will be helping Odji Akub during his entire performance.

Shekestaband's work:

- Cleans the wound with non-diluted Savlon.
- He starts from the small bleeding hole, and ending toward the cleanest part of the arm.
- No practical sense of organization in his work.

2. Identification of the Broken Place/Reduction of the Fracture

- The mullah is sitting now.
- Abdul Hakim says that he does not have any analgesic - the Shekestaband looks quite annoyed.
- He is pulling up the humerus to get a 90' angle between the body and the upper arm. the lower arm hanging perpendicular to the upper arm. (cf Appendix 1)
- Now, he extends forward the whole arm into a straight position.
- Abdul Hakim is supporting Mullah's body in maintaining the whole arm straight. (Appendix 2) The muscle is well relaxed.

Reduction of the fracture

- Odji Akub is now searching for the broken place. He is also checking if any pieces of bone are moving inside the flesh. His movements are gentle. He is pressing repeatedly, like a smooth massage with the tip of his fingers, or the palm of his hand. The traction is continuous. (Appendix 3)

3. Immobilization:

- No moving piece of bone was found.
- Until the end of the dressing, traction with two people, one at each extremity, is maintained.

1st Bandage

- 1 triangular white sling is torn with a mujahid pocket knife into a band of 5cm x 1.5m.
- The strip has to be very tight. Only one is being prepared.
- Odji Akub starts to wind the strip around the upper part of the arm.

- The three small wounds are proximal. They are kept uncovered by the strip.

2nd Bandage

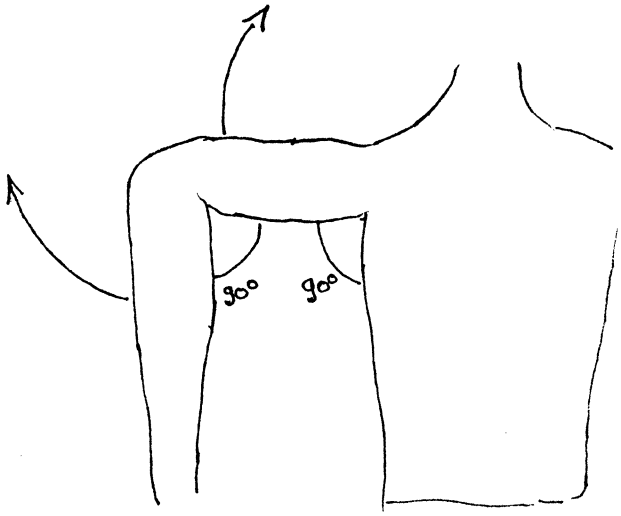
- Other strips are prepared. They will be 3cm x 1 meter. Two will be necessary.
- This bandage is covering the first one, but not as tightly. It seems very important that the band does not pleat.

3rd Bandage

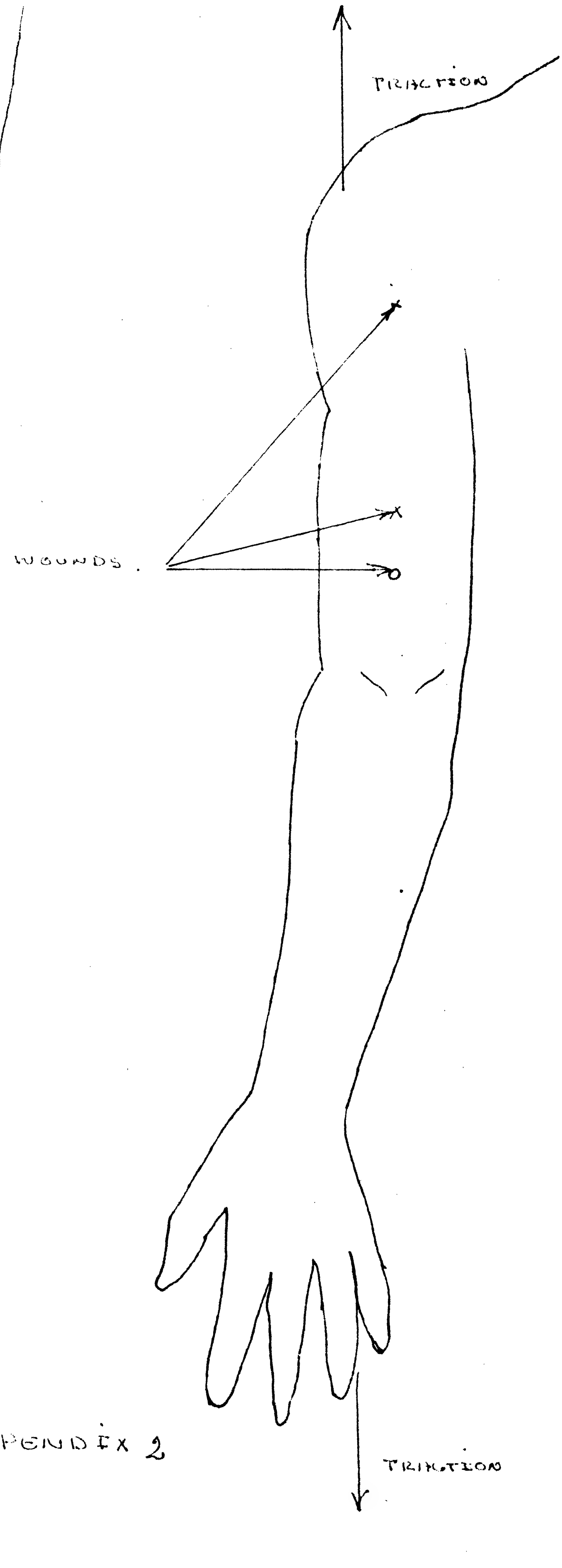
- Pieces of wood are being whittled into shape. They are 15cm x 2cm. Extremities will be rounded. (Appendix 4) 7 pieces are under preparation.
- The Shekestaband is placing them circling around the upper arm.
- He is fixing all of them with a 20cm x 2cm band, tightened on the upper part of the arm.
- Two smaller pieces of wood are cut (Appendix 5)
- The first one is inserted under the upper band.
- The second is maintained by Odji Akub's fingers. They allow the fracture to be immobilized, thus leaving the wound exposed for dressing changes. (Appendix 6)
- Tightened by the upper band of sheet, the lower extremity of the wooden sticks are still free. This permits to adjust them perfectly straight and parallel.
- Before tightening them, with the second 20-15cm x 2cm band, the Shekestaband inserts a piece of cotton under the 2 smaller sticks, to protect the skin from abrasion.
- Odji Akub brings a new strip and winds it several times around the arm, starting at the middle of the humerus. Before tightening the strip, he checks all the sticks.
- This band is applied very tightly.
- Then he ties the second lower strip.
- He finishes with the third upper band and leaves the wound open to air.
- Abdul Hakim fixes the arm in a Christopher position. (Appendix 7)

REMARKS:

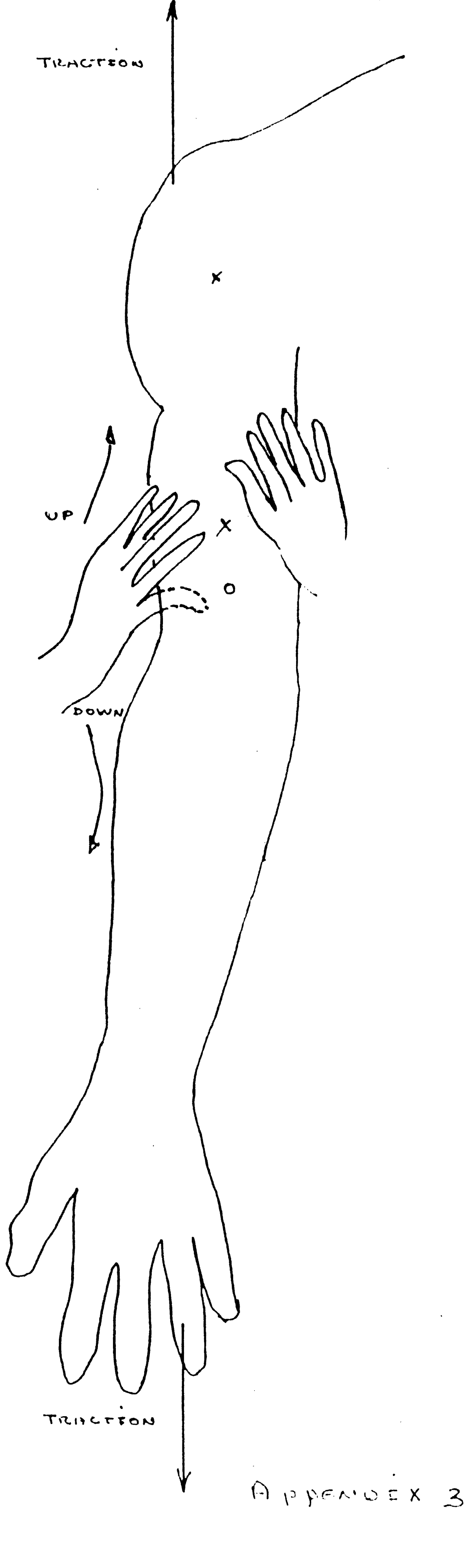
- The immobilization has to last for 30 days.
- After 15 days the patient will be allowed to move his arm a little.
- The radial pulse of the patient is still palpable but very faint.
- Principles of traction and immobilization are basic, but none of the joints above or below the fracture site were stabilized.
- The physiotherapy will be accomplished by his every day activities.



APPENDIX 1

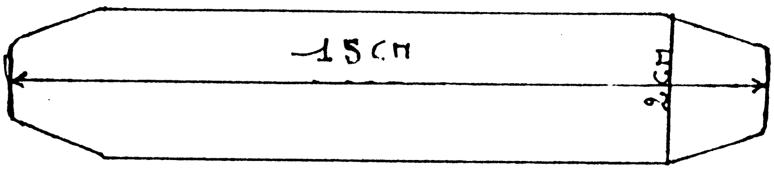


APPENDIX 2

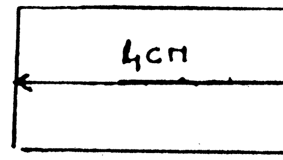


APPENDIX 3

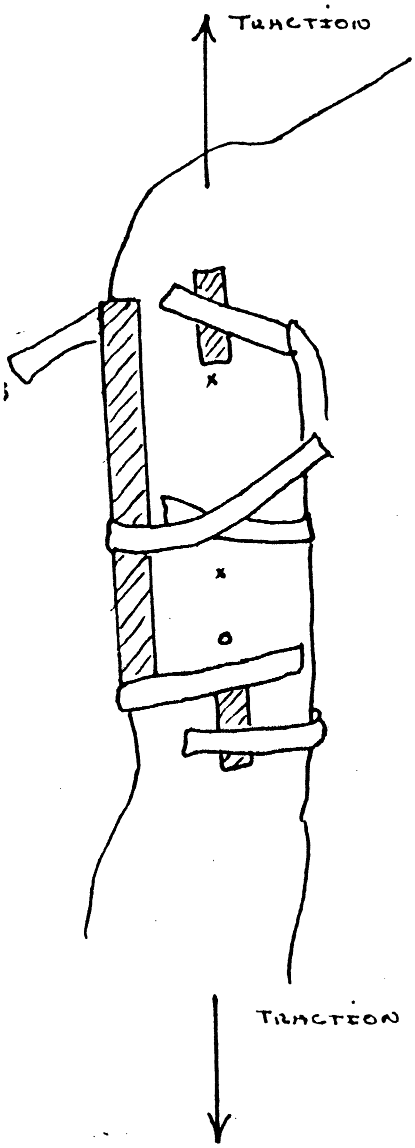
STICKS OF WOOD



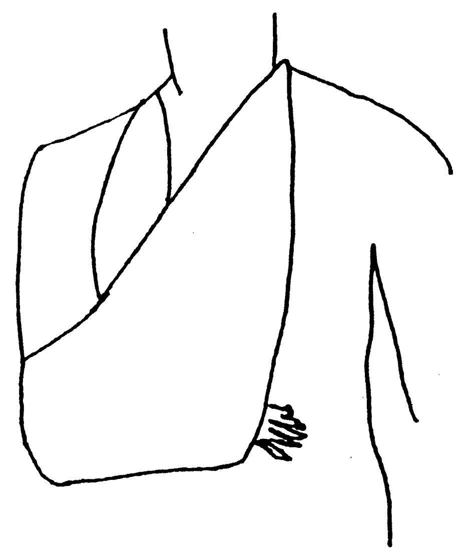
APPENDIX (4)



APPENDIX (5)



APPENDIX 6



APPENDIX (7)

In many cases, the HCW has allegiances to both the old and new political power structures. It is a serious problem when the HCW must choose to be more responsive to the dictates of one or the other.

Conditions Influencing HCW Quality of Practice

A few problems influencing the quality of the HCW practice became evident during the mission. The most serious difficulty is simply that he forgets what he has been taught. The duration of training appears directly related to the amount of information retained. Cardio-Pulmonary Resusitation instructors in the United States find that nurses and medical doctors who use CPR skills regularly in the course of their work are often unable to pass yearly recertification (written exam and practical performance), without "refreshing" their memories first. How can we expect people with 3-18 months training not to become victims of the same process of skill degradation. The need to establish continued medical education is well established within the educational and medical literature. The questions that follow are: over what time period does this occur, and when does it become dangerous?

Upon graduation, the HCW is sent to Afghanistan to work in a vacuum, with no way to review prior training, let alone increase knowledge and upgrade his skills. Many original teaching manuals have been lost or destroyed in the process of fighting a war. He has few, if any, reference or educational materials, and no resource people to provide supervision, instruction, advice, or act as role models. He has no referral system, and lacks an understanding of where he stands in relationship to the other levels of trained health care providers.

The job descriptions for HCWs are unclear; there are no standards of practice; and no understanding of standard drug supply according to the level of education. These problems leave the HCW with little idea of where he fits into the current or evolving system of health care.

The human tendency to strive toward self improvement brings predictable problems, in the absence of direction and support. Absurdly simple, but illustrating the problem, is the question: "How can we expect the young men we have trained to teach the making of ORS for the rest of their lives?" One can expect that these men would eventually desire elevation of social status, more professional recognition, better income for their families, increased self respect, and expansion of their knowledge and skills. Left in a vacuum they are forced to create their own pathways toward achieving their personal goals, with whatever resources are locally available.

GENERAL REPORT

CMC MONITORING MISSION #3

KANDAHAR PROVINCE

THE COORDINATION OF MEDICAL COMMITTEES

GENERAL REPORT OF CLINICS MONITORED IN KANDAHAR PROVINCE

MARCH - APRIL 1989

The Coordination of Medical Committees
25-C Circular Road
University Town, Peshawar
Tel. 42093

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